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Study exploring the relationship between personal trauma, gender, and the experience of vicarious trauma among counseling professionals

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A STUDY EXPLORING THE RELATIONSHIP BETWEEN PERSONAL TRAUMA, GENDER, AND THE EXPERIENCE OF VICARIOUS TRAUMA AMONG COUNSELING PROFESSIONALS

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ABSTRACT

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The purpose of this study was to identify the contributing factors of vicarious trauma among counseling professionals; more specifically this study explored the variables of a counselor's history of trauma, the type of trauma in their history, their gender and the number of clients on their caseloads with histories of trauma. A sample size of N=114 counseling professionals volunteered their participation in this study. Participants held master's degrees or higher in the fields of counseling, psychology, or clinical social work. Participants responded to questions on a demographics questionnaire and three additional assessment instruments: the Traumatic Life Events Questionnaire, the PTSD Screening and Diagnostic Scale, and the Trauma and Attachment Belief Scale.

The following research questions were explored in this study: (1) does a relationship exist between a mental health professional's history of trauma, symptoms of PTSD, and their experience of vicarious trauma? (2) Is there a difference between the categorical type of trauma (e.g., natural disaster, intimate partner violence, child abuse, interpersonal violence, accident and death or illness) experienced by a counselor and their experience of VT? (3) Are there gender differences in the frequency with which VT is

experienced? And (4) Is there a relationship between the number of clients with histories of trauma on a counseling professionals' caseload and their experience of VT?

Results from this sample population indicate no significant relationship was found between a counselor's history of trauma and their experience of vicarious trauma. However, results did yield a significant relationship between a counselor's symptoms of PTSD and their experience of vicarious trauma in this sample. A Pearson correlation coefficient was used to identify a relationship.

Results from this sample also found no difference among the various types of trauma in an individual's history as a contributing factor to vicarious trauma. A multivariate analysis of variance was used to identify if a difference existed between the types of trauma and no significant results were found.

To determine if there was a difference between men and women and their experience of vicarious trauma, a t-test was used. No difference was found, male and female counselors appear to experience VT at the same rates. Finally, a correlation coefficient was used to identify if a relationship existed between a counseling professional's experience of vicarious trauma and the number of clients on their caseload with trauma histories. No relationship was found between these two variables in this sample population

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CHAPTER I

INTRODUCTION

Trauma Work and the Effects on Counselors

Throughout history, societies have been plagued by war, famine, crime, and natural disaster. Globally, our world has witnessed the devastating effects of the Tsunami in Asia, genocide in Darfur and Rwanda, the wars in Iraq and Afghanistan, Earthquakes in China, the AIDS epidemic in Africa, and more recently, the earthquakes in Haiti and Chile. Americans have been, and continue to be, exposed to traumatic events; the Oklahoma City bombing of the Federal Building, the September 11th terrorist attacks on the World Trade Center buildings, Hurricane Katrina and its aftermath in New Orleans, and school shootings at Columbine High School, the Amish West Nickel Mines School and Virginia Tech. Each of these events resulted in the traumatic deaths of children, parents, family members, friends, and coworkers.

Following these catastrophic events, survivors may face emotional hardships as they grieve the loss of loved ones, loss of ability, or their former way of life. Both survivors and witnesses of such events may experience nightmares, flashbacks, or relive the event in vivid detail. These individuals may seek counseling to cope with the aftereffects of these tragedies thus secondarily exposing an entirely new, secondary group of individuals to various traumatic events. Mental health professionals providing services

to survivors of trauma are subjected to hearing personal recounts of tragic events while being professionally responsible for doing so by listening with sincerity, empathy, and compassion. As a result, mental health professionals are indirectly exposed to traumatic events through the experiences of their clients. For the purpose of this study, mental health professionals will be considered any individual with a professional Master's degree or higher, in counseling, counseling psychology, or clinical social work who is providing counseling services to clients. For the remainder of this document, mental health professionals will be referred to as counselors.

Trauma Response

Each of the tragedies stated above are generally perceived by society as traumatic events. According to Pearlman (2003), traumatic events affect the "victim's entire psychology, including defenses, coping styles, experience of self and others, self capacities, ego resources, psychological needs, ways of relating to others, world view, identity, and spirituality" (p. 3). For the purpose of this study, "trauma" will be defined as an event an individual has been exposed to which causes the individual to experience a flooding of intense stimulation beyond their control; causing distress, and leaving the individual feeling helpless and out of control (Briere & Scott, 2006; Cerney, 1995; Herman, 1992). Examples of traumatic events include, but are not limited to: natural disasters, the untimely or unexpected death of a loved one, sexual assault, intimate partner violence, child abuse, war, and motor vehicle accidents.

Individuals who have experienced distressing events and perceive these events to be traumatic may develop Post Traumatic Stress Disorder (PTSD) in response to the incident. PTSD is a psychological disorder which is used to define and diagnose those

who have been exposed to an extreme situation where they are threatened with death or severe bodily harm, and subsequently develop symptoms which define this disorder. Clients who are diagnosed with PTSD respond to the traumatic event with "intense fear, helplessness, or horror" (American Psychiatric Association, 2000, p. 463). Symptoms of PTSD include continuously re-experiencing the traumatic event, avoiding thoughts, feelings, and other activities related to the event, and experiencing an emotional numbing accompanied by a lack of interest in activities that the individual once found enjoyable (American Psychiatric Association, 2000). PTSD symptoms may also include intrusive thoughts about the event, flashbacks of the event, sleep problems, difficulty concentrating, and random outbursts of anger or irritability. In order for an individual to receive a diagnosis of PTSD symptoms must be present for at least one month or more and cause the individual serious distress (American Psychiatric Association, 2000).

Symptoms similar to PTSD exist in victims of secondary trauma; referred to as Secondary Traumatic Stress (STS). Figley (1999) defines STS as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 10). According to Figley (1995), symptoms of STS include dreams and recollections of the event, an effort to avoid thoughts, activities or situations serving as reminders of the event, withdrawing from others, sleep disturbances, hyper-vigilance, and irritability. It should be noted that these symptoms are almost identical to those of PTSD. Counselors working in settings where they encounter clients who have been traumatized and who are disclosing horrific stories may be susceptible to symptoms of STS.

The Cost of Caring

Since the late 1970's, Figley has been educating about the effects trauma has on individuals who have been exposed to devastating events. When PTSD was added to the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980), Figley expanded his work to include the effects of trauma on those indirectly exposed, for example family members, first responders (law enforcement, EMT's) and counseling professionals (Figley, 1995). Figley (1999) stated that simply "learning about" another individual's trauma can be traumatizing to the helper or family member. Figley (1999) labeled this type of experience STS or Compassion Fatigue (CF) and referred to it as the "cost of caring" (p. 10). The terms STS and CF are interchangeable (Baird & Jenkins, 2003; Figley, 1995; Figley, 1999; Kadambi & Ennis, 2004; Sabin-Farrell & Turpin, 2003; Salston & Figley, 2003) as both describe the effects of trauma work on providers. Symptoms of STS and CF parallel the symptoms of PTSD, where the primary individual exposed to a traumatic event may experience PTSD and the individual exposed to the traumatic event through a secondary experience (e.g., counseling a traumatized individual) may experience STS or CF.

Burnout. In addition to STS and CF, the term burnout has also been used in the literature to describe the emotional, psychological, and physical effects experienced by professionals who work with survivors of trauma (Kadambi & Ennis, 2004; Pearlman & Saakvitne, 1995a, 1995b; Sabin-Farrell & Turpin, 2003). Burnout occurs after extended professional work within a particular job or with a specific population. Individuals experiencing burnout are emotionally exhausted, disconnected from clients, and feel less accomplished in their work and other areas of life (Baird & Jenkins, 2003; Figley, 1995;

Kadambi & Ennis, 2004; Maslach, Schaufeli, & Leiter, 2001; Sabin-Farrell & Turpin, 2003). The onset of burnout is often prolonged and is a result of occupational stress (which can occur in any work setting), whereas STS is sudden and directly related to trauma work. Both CF and burnout can occur in any professional situation where clients are served, however STS is specific to trauma work (Figley, 1995; Pearlman & Saakvitne, 1995a, 1995b; Sabin-Farrell & Turpin, 2003; Schauben & Frazier, 1995; Trippany, White Kress, & Wilcoxon, 2004).

Vicarious trauma. In addition to burnout, STS, and CF counseling professionals are also susceptible to experiencing vicarious trauma (VT). VT is described as a potentially permanent change in an individual's core beliefs and cognitive schemas about the world and the individuals within it (McCann & Pearlman, 1990b). As with STS, VT is also exclusive to trauma work; it is the result of empathic engagement with clients and occurs after prolonged exposure to traumatic material (McCann & Pearlman, 1990b). Although the effects of VT may be considered permanent, there are mitigating factors present in its onset and ways in which VT may be prevented. These factors will be addressed in detail in subsequent chapters.

Vicarious Trauma

McCann and Pearlman (1990b) suggested that helping professionals accumulate memories of traumatic events revealed by their clients which has a profound and potentially permanent effect on the counselor's view of themselves, others, and the world. For example, counselors with an average concern for their personal safety and the safety of their loved ones may become overly concerned and hyper-vigilant about their safety after prolonged exposure to detailed accounts of traumatic events such as

childhood physical and sexual abuse. As a result of this heightened concern for safety, the counselor may no longer view people as good natured, and may impose more restrictions on his or her family's activities and their interactions with others. This phenomenon is known as VT (McCann & Pearlman, 1990b).

According to Pearlman and Saakvitne (1995a, 1995b), VT includes many of the same symptoms as STS. For example, counselors with VT may experience one or all of the following: flashbacks, intrusive thoughts, and avoidance of activities or places related to their client's descriptions of their personal traumas, as they would if they were experiencing STS. However, VT differs from STS as VT includes the extreme, potentially permanent, disruption of the counselor's sense of self, their view of the world, and their perception of others (Pearlman & Saakvitne, 1995a, 1995b).

VT is conceptualized by the Constructivist Self Development Theory (CSDT) and describes inevitable, potentially permanent changes in the counselor's belief system (Pearlman & Saakvitne, 1995a, 1995b). These changes occur after prolonged exposure to clients and their personal accounts of traumatic experiences. STS is supported by observable PTSD symptomology and subsequent diagnosis and addresses more immediate responses to trauma exposure, whereas VT addresses more permanent, long-term effects of trauma work (Pearlman & Saakvitne, 1995a, 1995b; Sabin-Farrell & Turpin, 2003).

CSDT is the theoretical framework which supports VT. CSDT is a personality theory that provides an understanding of the complex, emotional responses and permanent cognitive changes trauma can have on an individual as well as the changes that may occur for counselors who work with trauma survivors (Pearlman & Saakvitne,

1995a). CSDT purports that humans construct their own reality through cognitive structures referred to as schemas: schemas are defined as "beliefs about oneself and about others" (Pearlman, 2003, p. 3), and they provide a framework for interpreting events and interactions. Schemas assist individuals in making sense of their world, themselves, their experiences, and their sense of self (or identity; McCann & Pearlman, 1990a; McCann & Pearlman, 1992; Pearlman & Saakvitne, 1995a, 1995b; Rosenbloom, Pratt & Pearlman, 1999).

When counselors experience VT, their schemas may transform. These transformations may be permanent. For example, a counselor who volunteers for the American Red Cross and responds to communities affected by natural disasters may begin to perceive a threat to their own sense of safety and the safety of their loved ones. They may also believe they are more vulnerable to loss than prior to their exposure to this type of trauma work. The cognitive schemas in place which protected the counselor and allowed the counselor to feel safe have changed as a result of their work with trauma survivors. The way the counselor made sense of their world and their experiences has changed.

Although symptoms of STS and VT are closely related, this study will focus solely on VT, its effects on counseling professionals, and the factors contributing to this phenomenon. Due to the fact that VT is described as long-term and permanent, whereas STS and burnout are not, counselors suffering from VT may potentially harm clients. Additionally, recent concerns have emerged in the literature regarding the existence and prevalence of VT thus supporting the need for a study which addresses these concerns.

Contributing Factors

Some of the common contributing factors to VT have been identified by Pearlman and Saakvitne (1995a, 1995b); these factors include harboring unprocessed traumatic material consisting of horrific images and narratives of client's trauma, client characteristics (including their personal histories, family background, exposure to trauma and related events, and their coping strategies), the client's level of suicidality, and the level of support from the counselor's employer, colleagues and family. For example, a counselor working in a community setting providing therapy to war veterans returning from combat, receiving very little supervision and support, may be at risk for experiencing VT. In addition, the social context in which the counselor is exposed to trauma is also a contributing factor; for example this same counselor working with combat veterans, who is exposed to scenes from combat in the news or other television programming, is at risk of experiencing symptoms of VT.

In addition to client characteristics, Pearlman and Saakvitne (1995a, 1995b) further suggest that personal characteristics of the counselor also put them at risk for experiencing VT. For example, a counselor's personality traits, their level of self awareness, or their own personal histories of trauma may make them vulnerable to VT. Additionally, poor training and preparation, and a lack of supervision may also increase their risk of experiencing VT (Pearlman & Saakvitne, 1995a, 1995b). The contributing factors mentioned most often in the literature are; the counselor's own personal history of trauma (Figley, 1995; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Salston & Figley, 2003), a large client caseload of trauma survivors (Chrestman, 1999; Kassam-Adams, 1999; Schauben & Frazier, 1995), and the counselor's lack of

experience in the field (Baird & Jenkins, 2003; Chrestman, 1999; Pearlman & Mac Ian, 1995).

One additional factor not addressed in the literature, but which may be of significance, is gender. Research supports that women are more likely than men to be exposed to incidents of trauma (Friedman, Resick, & Keane, 2007; Kimerling, Ouimette, & Weitlauf, 2007; Vogt, King, & King, 2007). Additionally, several studies on VT include a large sample of female participants (Baird & Jenkins, 2003; Brady, Guy, Poelstra & Fletcher Brokaw, 1999; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995), yet gender is not addressed in the literature as a potential factor in VT. Furthermore, Kassam-Adams (1999) found correlations between gender, trauma history, and PTSD and suggests further examination of these findings; which will be considered in this study, though from a vicarious perspective.

As previously stated, a counselor's own personal history of trauma has been considered a factor in their experience of VT. Studies indicate high rates of physical and sexual abuse among female and male mental health professionals (Elliott & Guy, 1993; Follette, Polusny, & Milbeck, 1994; Pope & Feldman-Summers, 1992). Thus, it appears as if counseling professionals are likely to have some history of trauma, particularly childhood abuse. Other studies investigate the relationship between an individual's previous history of trauma and their experience with VT. A study by Pearlman and Mac Ian (1995) found that counselors with personal histories of trauma reported more distress and disruptions in cognitive schema (VT) than those without histories. These disruptions occurred in the areas of safety, trust, esteem, and intimacy. Additional studies have supported these findings (Kassam-Adams, 1999; Trippany, Wilcoxon, & Satcher, 2003).

However, a study by Schauben and Frazier (1995) found that symptoms of VT were not related to the counselors' own history of victimization. As a result of these conflicting findings, further research is needed to determine if counselors with personal histories of trauma experience VT more than those with no history, which will be addressed in this study.

Gender and personal trauma history have been identified as potential contributing factors to VT; other research suggests that counselors with higher caseloads of clients with trauma, particularly sexual trauma, report more PTSD like symptoms (consistent with VT). These symptoms included distress, intrusive thoughts and images, anxiety, and increased levels of dissociation (Brady, et al., 1999; Chrestman, 1999; Kassam-Adams, 1999). In addition to PTSD like symptoms, Schauben and Frazier (1995) report that counselors who had a higher percentage of survivors of sexual abuse on their caseload experienced changes in cognitive schemas (VT), symptoms of PTSD, and self-reported VT; however Brady et al. (1999) found no significant changes in cognitive schemas among a similar population, a key feature in VT. Researchers continue to suggest that counselors with high caseloads of trauma survivors, particularly sexual assault, are at risk for experiencing VT; however discrepancies exist in relation to the extent to which cognitive changes take place.

Contributors to the literature on STS and VT state that STS and VT are inevitable and unavoidable when working with survivors of trauma (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Salston & Figley, 2003). However, others argue that VT is not as prevalent as suggested in some literature, and that literature on the treatment and self-care strategies may have been premature

(Bride, 2004; Devilly, Wright, & Varker, 2009; Kadambi & Ennis, 2004; Sabin-Farrell & Turpin, 2003). This study will explore the prevalence of VT in counseling professionals who serve clients with and without traumatic experiences as well as further explore personal characteristics of the counselor that may contribute to this phenomenon, such as gender and personal history of trauma.

Despite differing opinions about prevalence, it is important for counselors and supervisors to understand the frequency and consequences of VT. Pearlman and Mac Ian (1995) suggest a need for trauma work and training for individuals new to the field and strong supervision as well as strong supportive professional relationships with colleagues so that counselor's can process the horrific details they hear when working with survivors of trauma. Rosenbloom et al. (1999) also support strong supervisor relationships and organizational support for counselors at risk of experiencing VT. Figley (1999) proposes incorporating STS, CF, and burnout into the curriculum used to train counselors so it is continuously discussed with students. He also suggests that any upsetting or distressing material be processed confidentially with supervisors. Finally, Kassam-Adams (1999) and Sommer (2008) suggests supervisors and counselors have an ethical duty to explore self-care and coping strategies for counselors at risk of experiencing STS and VT. This study will attempt to address many of these recommendations by quantitatively identifying the individual counselor characteristics which may contribute to VT. Increased knowledge and awareness about the phenomenon of VT, its symptoms, and the factors which contribute to its existence can lead to appropriate supervision, interventions, and treatment for counselors experiencing impairment related to trauma work.

Need for the Study

Research suggests that through the therapeutic process of working with trauma survivors, counseling professionals are susceptible to experiencing VT. As stated above, research in the area of VT is dated, limited, and research outcomes are contradictory. Given the opposition in the literature regarding a counselor's previous personal experience of trauma, the lack of research identifying the type of trauma history of the counselor, the omission of gender as a potential factor, and the discrepancy regarding the number of trauma clients on a counselor's caseload as contributing factors in experiencing VT the intent of this research study is to provide further clarification regarding these concerns. Through the use of valid and reliable assessment instruments and quantitative research analysis, this study sought to identify the personal characteristics and experiences of counselors which may contribute to VT. It was also the intent of this researcher to verify the prevalence of VT in counselors who provide services to survivors of trauma as well as counselors providing services to general populations. Identifying contributing factors and prevalence of VT among counselors can be useful knowledge for supervisors and counselors alike when identifying prevention and self care strategies; thus perpetuating continued, competent counseling services to clients and potentially preventing counselor burnout.

The Council for Accreditation of Counseling and Related Programs (CACREP) develops standards of practice for counselor education programs. CACREP standards are in place to promote excellence in educational programs and to ensure these programs are meeting standards set by the counseling profession. Standards were changed in 2009 to address the changing needs of society, which included education on crisis response and

trauma counseling. It is now required that CACREP programs include course work addressing trauma and crisis work and that the curriculum includes knowledge of crisis intervention and psychological first aid as well as self-care strategies for counselors (CACREP, 2009). The current standards now include crisis and trauma education; however these standards do not address the potential effects of this work on counselors, they only specify that self-care is needed.

Understanding the impact of trauma work on counselors, the prevalence of VT, and the personal and organizational factors which contribute to VT will allow counselor educators, supervisors, and practicing counselors to address this in their coursework on trauma and crisis. For example, if a large caseload of clients with trauma is identified as a contributing factor to VT, organizations providing client services can more closely monitor the number of clients assigned to their counselor's caseload. Counselors in private practice may also consider capping the number of trauma clients on their caseload to prevent VT. If a counselor's personal history of trauma, the type of trauma experienced, and their gender are identified as risk factors, supervisors and counselors may acknowledge their own personal risk of experiencing VT as well as identifying the symptoms in their colleagues. If counselors and supervisors are educated regarding the prevalence of VT and the elements which contribute to the phenomenon they may be more likely to seek their own personal counseling and supervision when working with traumatized clients.

Supervisors and counselors with knowledge of personal and organizational factors which contribute to VT can identify at risk counselors and improve treatment modalities for this group, thus improving services to clients. With this information supervisors may

also be able to identify the appropriate course of supervision and training for impaired counselors. Now that current accreditation standards are addressing the needs for trauma education, further studies are needed to explore the effects that trauma work has on counselors working with this population. The intent of this study was to provide additional clarification regarding the phenomenon of VT which can be applied in counselor education, as well as provide further explanation of the factors which contribute to the experience of VT. This information may be helpful to agencies as they assign caseloads and to supervisors working with potentially impaired counselors.

Research regarding an individual's history of trauma as a contributing factor to VT is inconsistent and contradictory. Research which identifies the type of trauma experienced in a counselor's history has not been identified. Studies which review gender as a contributing factor as well as the number of trauma clients on a counselor's caseload are limited. This study further explored contributing factors to VT and addressed implications the results may have for supervisors and counselor educators.

Statement of Purpose

The purpose of this study was to determine which personal characteristics held by a counselor may lead to VT. More specifically, this research study attempted to determine if a relationship exists between a counseling professional's personal history of trauma and their experience of VT and if a relationship exists between counselor gender and VT. This study further identified if the type of trauma experienced by the counselor influences the degree to which VT is experienced. In addition, this study sought to determine if the percentage of trauma clients per counselor caseload can be considered a contributing factor to VT.

Research Questions

Q 1 Does a relationship exist between a mental health professional's history of trauma, symptoms of PTSD as measured by the TLEQ, and their experience of VT as measured by the TABS?

Q 2 Is there a difference between the categorical type of trauma (e.g., natural disaster, intimate partner violence, child abuse, interpersonal violence, accident, and death or illness) experienced by a counselor as measured by the TLEQ and their experience of VT as measured by the TABS?

Q 3 Is there a relationship between gender (as reported on the demographic questionnaire) and VT as measured by the TABS?

Q 4 Is there a relationship between the number of clients with histories of trauma on a counseling professional's client caseload, as reported on the demographics questionnaire, and the counseling professional's experience of VT as measured by the TABS.

Definition of Terms

*Burn Out***:** "a syndrome of symptoms that include emotional exhaustion, disconnection from clients and a lack of sense of accomplishment in one's work" (Kadambi & Ennis, 2004, p.5).

Cognitive Schemas: "beliefs about one's self and others" (Pearlman, 2003, p. 3).

Compassion Fatigue: also defined as Secondary Traumatic Stress

Counter-transference: "therapists' affective, cognitive, and behavioral responses to specific individual clients" (Kadambi & Ennis, 2004, p. 5).

Disrupted Beliefs: "a restriction of one's beliefs that aff**ec**ts his or her ability to relate to others in a healthy manner" (Pearlman, 2003, p. 13).

Mental Health Professional: A professional counselor, therapist, or psychologist.

Secondary Traumatic Stress : "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other- the stress resulting from helping or wanting to help a traumatized suffering person" (Figley, 1995, p. 7).

Traumatic Event: "an event in which the person is flooded with intense stimulation that he or she cannot control" (Cerney, 1995, p. 131).

Vicarious Trauma: "a transformation of the therapist's (or other trauma worker's) inner experience resulting from empathic engagement with clients' trauma material. That is, through exposure to clients' graphic accounts of sexual abuse experiences and to the realities of people's intentional cruelty to one another, and through the inevitable participation in traumatic reenactments in the therapy relationship, the therapist is vulnerable through his or her empathic openness to the emotional and spiritual effects of vicarious traumatization. These effects are cumulative and permanent, and evident in both a therapist's professional and personal life" (Pearlman & Saakvitne, 1995b, p. 1).

CHAPTER II

REVIEW OF THE LITERATURE

Natural disasters, accidents, crime, war, and death are inevitable, it is likely individuals will be exposed to one of these events during their lifetime. Given the potential devastation caused by these events, they may be considered traumatic. It has been reported that anywhere between 40% and 81% of the general population have experienced or witnessed a traumatic event (Bride, 2004; Briere & Scott, 2006; Elliott, 1997). Exposure to traumatic events can leave a person feeling vulnerable and overwhelmed potentially leading to psychological distress. Individuals under psychological distress may experience feelings of depression, anxiety, fear, hopelessness, and loss. In addition to individuals directly exposed to traumatic events, their family members, friends, and partners may also be impacted by the person's response to trauma. Furthermore, those close to the survivor such as first responders, crisis workers, counselors, and social workers, are also indirectly exposed to the trauma.

Survivors of trauma who experience psychological distress may seek additional services and support; service providers working with these survivors experience their own unique psychological responses to traumatic material. The reactions of these service providers may be based on direct exposure to the traumatic event as a first responder (e.g., paramedic or law enforcement), or indirectly through recounts of the survivor's

story (e.g., counselors, advocates, social workers, or psychologists). Crisis workers who personally experience psychological, emotional, or physical changes in response to another's traumatic event are experiencing what is known as Secondary Traumatic Stress (STS; Figley, 1995). Counselors undergoing changes in their thought process and in their views of the world, their perceptions of self, and their perception of others, are experiencing what is known as vicarious trauma (VT; McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995). A review of the literature will provide a definition of trauma as defined by the mental health profession, an overview of traumatic events and responses, and a detailed description of the impact trauma work has on counselors, particularly VT.

Counseling individuals who have experienced trauma and who are exhibiting symptoms of psychological distress profoundly impacts counselors (Rasmussen, 2005). In addition to STS and VT other terms have been used to describe the effects of trauma work on counselors for example; burnout, countertransference, and compassion fatigue have all been utilized in the literature. VT is a complex phenomenon that occurs as a direct result of working with survivors of trauma. Symptomology that exists in survivors of trauma may be adopted by the counselor; as a result permanent cognitive changes take place. Additionally, there is controversy regarding the existence and prevalence of VT and the factors contributing to this phenomenon. In an effort to clearly establish VT as a unique effect of trauma work, each of the above mentioned terms will be briefly defined and compared. Both STS and VT will be compared and discussed in further detail because VT does included many of the symptoms of STS; thus further description of trauma, trauma response, and VT is warranted.

Trauma

Definition of Trauma

Trauma must be defined to fully understand its impact on counselors working with survivors of traumatic events. According to the Merriam-Webster on-line dictionary the word trauma has its origins in the Greek language, meaning to wound or to pierce. The current dictionary definition for trauma is "an injury (as a wound) to living tissue caused by an extrinsic agent, *or* a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury, *or* an emotional upset" (Trauma, 2010 on-line). The definition of trauma, as it relates to the counseling profession, is defined as a disordered psychic or behavioral state resulting from severe mental or emotional stress, physical injury, or emotional upset.

The mental health profession (psychiatrists, psychologists, and counselors) defines trauma as:

> Exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (American Psychiatric Association, 2000, p. 463)

In the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000), traumatic events an individual may experience directly or witness include, but are not limited to: war, interpersonal violence (e.g., sexual assault, physical assault, or robbery), kidnapping, hostage situations, terrorism, torture, disasters, automobile accidents, or life-threatening illnesses. The DSM-IV-TR (American Psychiatric Association, 2000), also describes witnessed events as traumatic. These events may include, but are not limited to, observing the

serious injury or unnatural death of another person under violent circumstances (i.e., violent assault, accident, war, or disaster), or unexpectedly witnessing a dead body or body parts. In addition to experiencing or witnessing a traumatic event, trauma also includes events experienced by others that are learned about. Such events are similar to those stated above such as violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease (DSM-IV-TR, American Psychiatric Association, 2000).

Trauma can further be defined as an unexpected event which occurs and the individual who experiences that event finds it distressing and devastating. It is important to note that trauma can occur across the life span and is not limited to adulthood; both children and the elderly may be exposed to traumatic events (Courtois & Gold, 2009). While experiencing the traumatic event, the individual is inundated with intense stimulation that is beyond his or her control; for example an individual may experience a state of fear for their life during a car accident. The car accident in and of itself is not traumatic, but can become traumatic if the individual perceives it as such. If an individual believes an event to be traumatic, he or she may experience severe psychological responses as a result.

The most common psychological responses to such an event are Depression, Anxiety, and Post Traumatic Stress Disorder (Rosenbaum, 2004; Sher, 2004; Vogt et al., 2007). Individual responses to trauma may vary based on the following factors: Genetics, the individual’s history of trauma, their family

history, and the social reaction received in response to the trauma (Briere & Scott, 2006; Cerney, 1995; Everstine & Everstine, 1993). Each individual responds to trauma differently, some responses may be more severe than others.

Various life experiences can be categorized as traumas for example, natural disasters, interpersonal violence, large-scale transportation accidents, fires, auto accidents, rape, sexual assault, physical assault, and partner battery. Other types of traumas include war, torture, child abuse, sudden death, homicide, witnessing a tragedy, physical loss, and technological disasters (Allen, 1995; Briere & Scott, 2006; Everstine & Everstine, 1993; Fairbank, Putnam, & Harris, 2007; Rosenbaum, 2004). In a random sample of 526 participants, Elliott (1997) found that 72% of participants reported experiencing either a childhood or adult trauma. In a sample of 937 college students, Bernat, Ronfeldt, Calhoun, and Arias (1998) found that approximately 67% had reported experiencing at least one traumatic event. Given these findings it is likely that a person will directly experience one of these events in his or her lifetime; the effects of such an experience are potentially devastating.

In addition to specific types of trauma, trauma can be further classified as natural "acts of God" or accidental and man-made "acts of humans" (Allen, 1995; Courtois & Gold, 2009). Acts of God include events or situations that occur one time; for example natural disasters, physical or medical conditions, accidents, or other events which appear random and where responsibility cannot be assigned. Man-made trauma however, is often violent in nature, premeditated, and carried out deliberately where blame and responsibility can be assigned. This can include technological disasters or criminal

violence. Man-made traumas often involve a relationship (e.g., domestic partner, parent child) and some form of betrayal (violation of trust, caregiver causing harm).

Individuals also respond differently to trauma that is "natural" versus trauma that is "man-made." Survivors of man-made trauma, wherein a relationship between the victim and the perpetrator exists (e.g., parent child relationship, caregiver), and when the intent of the perpetrator is malevolent in nature, tend to be the most difficult form of trauma (Allen, 1995; Courtois & Gold, 2009). Trauma that is calculated as opposed to impulsive, and occurs in a relationship that involves emotion and attachment, may lead to more psychological distress (Allen, 1995).

Acts of God

Natural disasters. Natural disasters can be defined as large-scale, environmental events that adversely affect a large number of people (Briere & Elliott, 2000; Briere & Scott, 2006). Types of natural disasters include earthquakes, volcano eruptions, hurricanes, floods, tornados, fires, cyclones, and tsunamis. In a sample of 935 individuals from the general population, Briere and Elliott (2000) found that 22% of the sample had experienced a natural disaster and 64% of that population feared for their life at that time. Among participants, those who reported the presence of physical injury, fear of death, and property loss had symptoms of depression, intrusive experiences (flashbacks) avoidance, and anxiety.

Following the study by Briere and Elliott (2000), Americans were exposed to the destruction of Hurricane Katrina. Hurricane Katrina could be described as one of the most devastating natural disasters in U.S. history to date. In a study of 363 African American Hurricane Katrina survivors, Lee, Shen, and Tran (2009) found that 62.6% had

homes that were destroyed and 21.1% reported a family member, friend, or neighbor being killed. Natural disasters where property damage, physical injury, fear, and death occur could be perceived as traumatizing and psychological symptoms could develop for survivors and their loved ones.

Counselors may be vicariously exposed to natural disasters through their work. Counselors who provide services to survivors of natural disasters typically do so in the capacity of crisis response (e.g., FEMA, Red Cross). Under these circumstances counselors may provide support and comfort (Briere & Scott, 2006); however long term work with clients who have been severely traumatized by a natural disaster could potentially impact the counselor's personal beliefs about their own safety and the safety of their loved ones.

Illness and accidents. Other types of trauma included in the category of "acts of God" are accidents and illness. Individuals often perceive trauma as a threat against their physical existence which results in feelings of stress and vulnerability (Richmond & Kauder, 2000). According to the CDC (Center for Disease Control and Prevention; 2008, p. 19) in 2004 there were 33million injuries requiring medical attention, and 167,184 deaths resulting from injury. In the same report, motor vehicle traffic accidents remain the leading cause of injury death in the United States (p. 30). Many of these individuals develop psychological symptoms as a result of their own serious injury or the death of another (Briere & Scott, 2006). Richmond and Kauder (2000) found that moderate and high levels of psychological distress often occur after physical injury, and in some individuals their level of distress increased in the months following the injury. Furthermore, family and social support systems may also be impacted.

In addition to injuries and motor vehicle accidents, numerous individuals are diagnosed with potentially deadly diseases such as cancer and AIDS. According to the CDC, there were 35,962 new AIDS cases diagnosed in 2007 (CDC, 2009, p. 285). Individual responses to medical diagnosis may vary and many responses may include psychological stressors.

Bereavement counseling includes support and therapy for those who have lost a loved one and those preparing to die. Counseling this population includes a risk for personal suffering for the counselor and may lead to burnout, VT, compassion fatigue or STS (Puterbaugh, 2008). Counselors who work with the terminally ill or those who have been seriously injured may do so in private practice, with Hospice, community mental health agencies, rehabilitation agencies, or hospital settings. Additionally, in some states where permitted, counselors may work with clients who are making end of life decisions. Providing services to terminally ill clients or those suffering from injury can have an impact on counselors.

Man Made Trauma

War. There are various types of man- made traumas, particularly those that result from war and other forms of violence. Trauma resulting from war is "severe, repeated, and prolonged" (Allen, 1995, p. 7). Those exposed to war may see violence and death on a large scale. In addition to potentially being killed during war, they witness the death and mutilation of others. Finally, those who participate in war may be expected to kill, harm, and possibly even torture others; for example killing a perceived enemy, torturing prisoners of war (POW) or abusing inmates in prison (e.g., Abu Ghraib).

In addition to those exposed to war, engaging in war related activities can have a profound effect on one's mental health and sense of self (Allen, 1995; Courtois & Gold, 2009). Furthermore, children are not immune to being exposed to war. Children who experience war-zone and refugee violence either live in a region exposed to violent acts of war (shootings, bombings, and other warfare), or they are displaced to other areas (e.g., refugee camps) to avoid persecution. In many locales, children are not just exposed to war but are forced to become soldiers and participate in combat (Fairbank, et al., 2007).

Veterans returning from war may seek counseling services for PTSD, depression, substance abuse, anxiety, or traumatic brain injuries (TBI). The most frequently reported mental health concerns after deployment are Depression, PTSD, and Generalized Anxiety. Some veterans serving in Iraq and Afghanistan are serving more than one tour of duty and at least 20% of those veterans are diagnosed with PTSD or Depression (Danish & Antonicles, 2009; Hoge, Castro, Messer, McGurk, & Koffman, 2004; Owens, Herrera, & Whitesell, 2009). PTSD is more prevalent than depression and affects between 5% and 15% of those deployed. Depression ranges anywhere between 2% -10% of those deployed (Ramchand, Karney, Osilla, Burns, & Calderone, 2008). Counselors working with veterans may do so on military bases, in private practice, veteran hospitals, and community mental health settings. Some may receive services in settings where they are also being treated for physical injuries.

Interpersonal violence. In addition to war, other forms of man-made traumas include interpersonal violence, violence with mass casualties (e.g., school and campus shootings), workplace violence, rape and sexual assault, physical assault perpetrated by

stranger (e.g., mugging, kidnapping, physical fight), and intimate partner violence (domestic violence). In a report on crime in the United States, the Federal Bureau of Investigation (FBI; 2008) announced an estimated 1,382, 012 violent crimes occurred in the United States (US). It is important to note that criminal violence not only impacts the primary victim, but can also severely affect those who witness the criminal act as well as those who support the victim (e.g., family and friends; Allen, 1995; Courtois & Gold, 2009). A recent example of such tragedy would include the shootings that took place at Virginia Tech where 33 students and faculty were killed, and at least 15 wounded (Hauser & O'Connor, 2007). This type of incident may affect the victim's families, as well as other students, first responders, coworkers, and the community as a whole.

When working with survivors of crime and abuse, counselors are at risk for experiencing symptoms of STS and VT. For example, Iliffe and Steed (2000) found that counselors working with survivors of domestic and intimate partner violence report feeling horrified by stories they have heard. Additionally they report believing they could no longer be shocked by descriptions of abuse. These counselors reported experiencing visual imagery related to the stories of abuse they have heard and believing some of those images will remain with them forever. As a result of their work with survivors of domestic violence, counselors also reported feeling less safe themselves and for their families. Counselors providing services to victims of crime may do so in law enforcement and advocacy settings, private practice, and community based mental health settings.

Child abuse. Child abuse is another form of interpersonal violence. Children may be exposed to the following types of trauma; child maltreatment, physical abuse,

neglect, emotional abuse, and sexual abuse. Other types of childhood trauma include witnessing domestic violence or intimate partner violence (including physical or sexual violence, both threatened and actual), as well as emotional abuse between adults or caretakers in the child's home (Fairbank et al., 2007). Adult survivors of adverse childhood experiences are more likely to experience depression (Chapman, et al., 2004), substance abuse (Dube, Anda, Felitti, Edwards, & Croft, 2002; Elam & Kleist, 1999; Schilling, Aseltine, & Gore, 2007; Wu, Schairer, Dellor, & Grella, 2010), PTSD (Wu et al., 2010), and Anti Social behaviors (Schilling et al., 2007). Counselors may work with survivors of child abuse both as children and adults in private practice, community mental health agencies, inpatient treatment programs, private practice, advocacy settings, or school settings.

Technological disasters. The final category of "man made" traumas includes technological disasters. Technological disasters involve what is known as Major Hazard Installation (MHI) or hazardous substances. These substances can be found in refineries, petrochemical plants, chemical production plants, water treatment facilitates, etc. Accidents with MHI materials often involve fires, explosions, and toxic release where toxic release typically causes the greatest number of fatalities (Shaluf, 2007; Shaluf, 2008).

These disasters are considered man made because the accidents are caused by failures in design, equipment, supplies, and procedures affecting the facility and potentially the surrounding community (Shaluf, 2007). Technological disasters include chemical spills, nuclear reactor failures, and other man-made disasters (Allen, 1995), like oil rigs burning and sinking in the Gulf of Mexico. The evacuation of employees or

community members during a technological disaster can cause elevated levels of stress and feelings of helplessness as they are often unpredictable (Lang, Toussaint, & Fleming, 2004).

Individuals who have been exposed to “man made” traumas, acts of God, or both have varied psychological responses to the trauma. Many people believe they are “going crazy” when in reality their response is normal. The more severe the trauma or when multiple traumas are experienced, the more likely the effects are to be psychologically damaging. The greater the psychological stress response to trauma the more likely a person is to develop PTSD. The psychological response is more likely to be severe if the trauma occurs repeatedly, is man-made and malicious in nature, unpredictable, perpetrated by a caregiver, or occurs during childhood (Allen, 1995).

In addition to defining what constitutes a traumatic experience, it is also important to describe the possible psychological responses to such an event and the severity of those responses; the most common being Depression, Anxiety, and Post Traumatic Stress Disorder (Rosenbaum, 2004; Sher, 2004; Vogt et al., 2007). As previously stated, counselors who work with survivors of trauma are also impacted and can experience the symptoms of burnout, STS, and VT as a result of their work. Therefore, it is important to understand how individuals respond to trauma so that we may further understand how counselors are affected.

Response to Trauma

Power and terror are often involved during a traumatic experience (e.g., child abuse, war, rape) and individuals are left feeling helpless or out of control. As a result, survivors of traumatic events tend to respond biologically and emotionally to the

presenting circumstances (Figley, 1986; Herman, 1992). When the nervous system is stimulated, the individual experiences a rush of adrenaline, which pushes them into fight or flight mode. Emotional responses, under these intense experiences, include feelings of anxiety, helplessness, and the belief that no action or escape is available (Allen, 1995; Herman, 1992). For some individuals, these normal emotional responses may persist for a longer period of time, which may lead to more severe psychological concerns. Furthermore, counselors working with individuals under these circumstances are also susceptible to strong emotional reactions and potentially permanent cognitive changes.

Biological Response

The sympathetic nervous system is responsible for the fight-or-flight response that occurs when a person is under extreme stress. Under stressful or threatening circumstances the brain increases the production and release of norepinephrine, which allows an individual to respond appropriately to a situation (fight-or-flight). When the stressor is no longer present, the nervous system typically returns to its normal state. For individuals who have experienced trauma this normal state is interrupted: Increased levels of neurohormones, like norepinephrine, are associated with other symptoms such as anxiety, hyperarousal, and re-experiencing the event (Briere & Scott, 2006).

Following a traumatic event, survivors often experience an on-going state of hyperarousal, meaning they are always alert, expecting the traumatic event to re-occur at any moment. The hyperaroused individual may have poor sleep patterns and startle easily. These individuals are rarely in a relaxed state, but are often aroused and prepared to physically and emotionally respond to stimuli in anticipation of threat or danger. According to Herman (1992), traumatic events potentially restructure an individual's

nervous system. Additionally, trauma survivors also experience intrusive thoughts and memories of the traumatic event, as if it were presently occurring. These intrusive cognitions come in the form of dreams, thoughts, memories, or actions (Allen, 1995; Herman, 1992). Often times, they are unsolicited and unplanned and can happen with the same power and strength as the initial event.

Psychological Response

Direct and indirect exposure to an event where an individual's life is in danger, where their body can be exposed to destruction or loss, or the individual is subject to ridicule, manipulation or humiliation, can also lead to psychological distress (Sher, 2004; Titchener, 1986). Psychological symptoms may emerge in response to the event or severe disruption in a person's natural state of balance caused by the traumatic event (Everstine & Everstine, 1993). Any classification of trauma can cause a manifold of responses including those perceived as minor to responses that are harmful, detrimental or even fatal. Some reactions or responses to trauma will diminish in time with assistance and support (Courtois & Gold, 2009).

Traumatic events shatter a survivor's assumption of safety. Trauma challenges, and at times even breaks an individual's trust in others or their relationships. A traumatic event can also alter the individual's sense of self leaving them feeling shame, guilt and doubt. Individual's feel shame as a result of their helplessness. If an individual survived an event where they witnessed the death of others (e.g., war) they may experience extreme survivor guilt. Individuals who have survived trauma may also begin to question their faith, experience doubt, and believe they cannot be their true selves around others (Herman, 1992). Individuals can also experience shame as it relates to specific thoughts

and behaviors they experienced during the trauma. Counselors experiencing VT may also share these feelings. They may begin to question their faith or spirituality, experience fear for their own safety, or for the safety of others.

In addition to feelings of shame and guilt, individuals exposed to trauma may also be in jeopardy of developing severe psychological responses. The most common psychological responses are Depression, Generalized Anxiety, Substance Abuse, and PTSD (Briere & Scott, 2006; Friedman et al., 2007; Kimerling et al., 2007; Rosenbaum, 2004; Sher, 2004; Vogt et al., 2007). Other diagnoses related to trauma include Acute Stress Disorder, Dissociation, Bipolar Disorder, types of psychosis, and other personality disorders, although these responses are not as common as those previously stated (Briere & Scott, 2006; Courtois & Gold, 2009). Furthermore, children exposed to adverse childhood experiences are at an increased risk of developing substance abuse behaviors, attempting suicide, sexual promiscuity, overall poor mental and physical health including obesity and sexually transmitted diseases (Fairbank et al., 2007). The psychological effects of trauma are profound.

Depression. As previously stated, depression is one of the more common psychological responses to a traumatic experience. An individual with depression experiences a depressed mood for most of the day, nearly every day. A depressed mood often means the individual feels sad or empty, or they appear tearful. Symptoms of depression include a lack of interest or pleasure in most activities, significant changes in weight (loss or gain), significant changes in appetite, and a lack of sleep or over sleeping. Depression also includes feelings of restlessness, fatigue or loss of energy, feelings of worthlessness or guilt, and a diminished ability to think or concentrate. Depressed

individuals may experience recurrent thoughts of death or suicide (American Psychiatric Association, 2000).

Anxiety. In addition to depression, traumatized individuals may also experience anxiety. Anxiety includes feelings of apprehension and worry. To be diagnosed with an anxiety disorder, an individual must experience excessive anxiety and worry on most days for at least six months. The anxiety can be about various life events such as school, work, finances, or interpersonal relationships. An individual with anxiety finds it difficult to control their worry, they also may feel restlessness or on edge, irritable, tired, or have trouble concentrating. Additionally, they may experience biological responses related to anxiety such as muscle tension and sleep disturbance. Feelings of anxiety may be present in traumatized individuals and individuals with PTSD; however it is important to note that although feelings of anxiety are present in PTSD, a diagnosis of anxiety is separate from PTSD (American Psychiatric Association, 2000).

Substance abuse. Substance abuse is also common among individuals who have experienced trauma. An individual with substance abuse concerns takes drugs or alcohol, which can include prescribed and over-the-counter medications. Symptoms of substance abuse include impairments in cognition or mood, feelings of anxiety, hallucinations, delusions, and seizures. These symptoms typically disappear when the individual is no longer exposed to the substance of choice (American Psychiatric Association, 2000). As previously stated, substance abuse is also common among adult survivors of adverse experiences.

Post Traumatic Stress Disorder. Finally, a diagnosis of PTSD is a possibility for many survivors as it is a trauma specific psychological disorder. There are common

psychological responses to traumatic events, if these psychological responses are re-occurring and happen consistently for an extended period of time they can be symptoms of Post Traumatic Stress Disorder (PTSD). PTSD is defined by the DSM-IV-TR (American Psychiatric Association, 2000) as the development of symptoms following exposure to an "extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to another person" (p. 463).

The DSM-IV-TR (American Psychiatric Association, 2000) also specifies that learning about an unexpected or violent death, serious harm, or threat of death or injury experienced by a friend or family member may also lead to symptoms of PTSD. In order to receive a PTSD diagnosis the individual's response to the event must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event, avoidance of things associated with the trauma, and feelings of numbness.

An individual with PTSD commonly makes deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event; and avoids activities, situations, or people who arouse recollections of the event. This avoidance of reminders may include amnesia for an important aspect of the traumatic event. Individuals with PTSD experience diminished responsiveness to the external world (numbness) and may complain they no longer enjoy or are interested in previously enjoyed activities. Additionally, these individuals feel detached from other people, have a reduced ability to

feel emotions and may not sense a foreseeable future (American Psychiatric Association, 2000).

Each of the possible psychological response to trauma are likely to include potential risk factors, however the focus of this study is the effects of trauma work on counseling professionals. Since some of the symptomology of STS and VT are closely related to PTSD, risk factors for PTSD are described here to further contribute to understanding these phenomena. Risk factors for developing PTSD include exposure to previous trauma, characteristics of the traumatic event (e.g., type of crime, natural disaster, or abuse), any preexisting attributes or experiences of the trauma survivor (e.g., current mental health, previous trauma experiences, personality traits), and post trauma circumstances (e.g., social support; Rosenbaum, 2004; Vogt et al., 2007).

Individuals whose personality traits contribute to their vulnerability to stress, those who have had previous exposure to trauma, individuals with a family history of psychiatric disorders (especially depression), and their previous life experiences all contribute to their risk of developing PTSD (Rosenbaum, 2004; Sher, 2004). Furthermore, risk increases in individuals with below average intelligence, limited education, those from a lower socioeconomic status, and individuals of minority races (Vogt et al., 2007). Several of these risk factors are also consistent with the risk factors of VT, which will be described further along in this review of the literature.

Additionally, there is an association between the severity of threat experienced during a traumatic event (e.g., loss of life versus loss of material possessions) and PTSD (Sher, 2004; Vogt et al., 2007). Traumatic events which involve some form of injury; are

malicious in nature, such as assault, and where the individual is actively involved versus witnessing the event increase the likelihood of PTSD (Vogt et al., 2007).

In an effort to further understand VT and its contributing factors, it is necessary to describe and define trauma, the psychological responses to trauma, and the effects of trauma on individuals; however it is important to note that most people will not develop PTSD in response to a traumatic event. The majority of people have enough resilience to guide them through the traumatic event and protect them from severe psychological distress (Friedman et al., 2007). Those individuals more severely traumatized, and those with risk factors for developing PTSD may seek counseling services in response to their traumatic experience, potentially having an effect on the counselor.

Social Response

Individual responses to trauma have previously been described in detail; however there are also social responses to be considered. As previously stated individuals experiencing trauma can feel helpless and out of control (Figley, 1986). In addition to feelings of vulnerability, survivors of trauma may also experience negative reactions from others because societal beliefs about interpersonal violence (e.g., rape, incest, war, and domestic violence) can be negative and damaging at times. Receipt of social support from family, friends and community may decrease the likelihood that individuals exposed to trauma will develop psychological symptoms, specifically PTSD (Friedman et al., 2007; Kimerling et al., 2007; Rosenbaum, 2004; Vogt et al., 2007). It is also important to acknowledge that development of PTSD and its symptoms may exhaust social support and resources over a period of time (Vogt et al., 2007) and in some circumstances traumatizing and distressing those offering support (Figley, 1986; Figley, 1999).

Given the potentially harmful reactions to trauma and trauma victims inflicted by society, positive social support is essential to emotional recovery. Figley (1986) describes social support as the ability of an individual to rely on others for emotional or physical care and comfort in their time of need. Figley (1986) further identifies five functions of support significant to an individual suffering from trauma which are; emotional support, encouragement, advice, companionship, and tangible aid.

Societal response to survivors, who have experienced more humiliating or socially taboo traumas, is often based in misperceptions. Everstine and Everstine (1993) describe various societal perceptions of trauma victims to be associated with "weakness, cowardice, hysterical exaggeration, or outright malingering for financial gain" (p. 15). For example, common societal beliefs about victims of rape impose expectations that if victims do not fight back it is not rape or victims of a natural disaster take advantage of services for financial gain. These perceptions often leave survivors feeling ashamed, helpless, and cautious when sharing their thoughts, feelings, and experiences.

In addition to negative responses, popular belief and generalized thinking that an individual is in control of their own destiny contributes to blaming the victim of a trauma, implying that the victim could have somehow prevented the traumatic event from occurring. An example would include intimate partner violence, when the victim is asked how he or she provoked an attack from their partner or failing to evacuate when notified of a potential natural disaster, or being severely injured while driving under the influence of alcohol. Survivors of trauma may also perceive these misperceptions as truth, in return accepting the traumatic event to be punishment for thoughts and behaviors they perceive as wrong (Everstine & Everstine, 1993).

Women are susceptible to additional inimical responses from society. Women experience more traumas and are more susceptible to becoming victims of vicious, intimate or interpersonal acts tied to adverse social response. Women are also more likely to reveal their victimization than their male counterparts, reporting harsh, negative social outcomes at nearly twice that of men. After experiencing a trauma, women are twice as likely to develop PTSD as males with greater severity of PTSD symptoms (Allen, 1995; Briere & Scott, 2006; Friedman et al., 2007; Kimerling, et al., 2007; Sher, 2004). For example women are often the victims of rape, sexual assault, sexual abuse, and intimate partner violence and these types of trauma likely condition negative and hostile societal responses.

Although the traumatized individual may be exposed to negative social reactions, emotional support, particularly the support of family, may deter the onset of PTSD and its symptoms in trauma survivors. Family members can help detect symptoms if they emerge through identifying changes in mood or by detection of emotional upset. Family can help the individual confront the problem and deal with it appropriately. Families also provide much needed support by encouraging the individual to reconsider the traumatic events helping to alleviate any distorted feelings of guilt or other self-destructive emotions. Finally, family support helps resolve any conflicts associated with the traumatic event through objectivity (Figley, 1986). In addition to therapy, support from family and others in the community may reduce an individual's risk for experiencing PTSD related to the trauma.

Treatment of Traumatized Individuals

Counselors working with survivors of trauma can be exposed to any number of the traumatic events described earlier as well as a range of psychological responses, which have also been described in detail. The counselor's level of exposure will depend on their caseload of clients and the type of therapeutic interventions and treatment they engage in with their client. A client's experience of trauma can be defied in six steps; 1) experiencing a traumatic event, 2) attempting to deny the event, 3) accepting the reality of the trauma, 4) entering into a cognitive survival state (which may included identifying with the aggressor), 5) experiencing shock, and 6) responding to the trauma (Everstine & Everstine, 1993). Counseling interventions with individuals who have experienced trauma typically involve facilitating the process of working through the traumatic experience, at which time the client gradually relives the event in great detail (Bride, 2004). There are many theory based techniques which can be used during the therapeutic process; the most common are Cognitive Behavioral Therapy (CBT) and Psychodynamic therapy, along with other eclectic approaches (Briere & Scott, 2006). These approaches address specific therapeutic needs of trauma survivors including the need for psycho-educational information about trauma, respectful therapy, stress reduction techniques, cognitive interventions which address trauma related beliefs and assumptions, memory processing, and developing a healthy narrative of the traumatic event (Briere & Scott, 2006). During therapeutic interventions when the client is processing memories of the trauma and creating a healthy narrative, the counselor is exposed to the vivid details of the client's trauma. Exposure to such graphic details on a regular basis may put the counselor at risk of experiencing STS and VT.

Effects of Trauma Counseling on Counselors

Emotions are infectious and counselors can be influenced by the emotions of their clients. Counselors work with clients to assist them in processing, understanding, and exploring their emotions. As a result of this very intimate and intense process, the emotions of the counselor become stimulated by an invasion of the client's feelings (Rothschild & Rand, 2006). Figley (1999) describes trauma as "contagious" (p. 9). He states those most "vulnerable to this contagion are those who begin to view themselves as saviors, or at least as rescuers" (p. 9). Pearlman and Saakvitne (1995a, 1995b) write that after a trauma nothing will be the same. As counselors confront this reality with clients, they also recognize the potential for loss and devastation in their own lives. Pearlman and Saakvitne (1995a) further describe trauma therapy as an assault on a counselor's personal beliefs about their safety and connection to others. Counselors who possess qualities such as empathy and genuineness, and who are involved in a survivor's recovery process from a trauma, may be vulnerable to the "contagion" of trauma.

Empathy is the experience which allows counselors to connect with their clients and understand how and what they are feeling. Empathy assists counselors in gaining insight and perspective into the lives of their clients (Figley, 1995; Figley, 1999; Rothschild & Rand, 2006). Empathy is an essential tool in counseling, one that allows the counselor and client to become emotionally invested in the therapeutic relationship. In trauma therapy, empathy is the tool most often used to connect to a trauma survivor who is emotionally distraught and devastated (Pearlman & Saakvitne, 1995a, 1995b).

Use of empathy when counseling survivors of trauma exposes the counselor to overpowering emotions (Pearlman & Saakvitne, 1995a, 1995b). Counselors can be

affected both mentally and physically by a client who is suffering; as a result the counselor may experience PTSD like symptoms, otherwise known as STS (Chrestman, 1999; Figley, 1995; Figley, 1999; Rothschild & Rand, 2006); or a disruption in their belief system referred to as VT (Pearlman & Saakvitne, 1995a, 1995b). Additional terms used to describe the impact of counseling survivors of trauma include burnout, countertransference, and compassion fatigue.

Burnout

Burnout occurs over the course of time and applies to anyone whose physical and mental health is wearing, someone who feels discouraged and has a negative outlook on life due to prolonged exposure to job stress, and intensive work with clients (Devilly et al., 2009; Figley, 1995; Figley, 1999; Maslach, et al., 2001; Rothschild & Rand, 2006; Rudolph, Stamm, & Stamm, 1997; Salston & Figley, 2003). Symptoms of burnout include exhaustion, distancing oneself from clients, cynicism, inefficiency, symptoms of depression, and poor work performance (Maslach et al., 2001). Factors contributing to burnout among counseling professionals include limited support and supervision and caseload satisfaction (Devilly et al., 2009). Additionally, burnout can occur in most professions and is not limited to counseling whereas VT is unique to trauma counselors.

Countertransference

Countertransference has roots in psychodynamic theory and is defined as an affective, ideational, and physical response, or emotional reaction a counselor has towards their client (Figley, 1995; Pearlman & Saakvitne, 1995a). These responses are present in all therapeutic relationships; however the type of countertransference

interaction is specific to the individual therapist and client. Countertransference often interferes with the counselor's ability to be therapeutic with the client.

Countertransference, as it relates to the counseling relationship, can amplify a therapist's vulnerability to VT. Whereas countertransference is unique to the individual counselor / client relationship, VT is the result of a conglomeration of therapeutic interactions and experiences. It extends beyond the therapeutic relationship and impacts the counselor both professionally and personally (Pearlman & Saakvitne, 1995a). According to Pearlman and Saakvitne (1995a), VT shapes countertransference.

Compassion Fatigue and Secondary Traumatic Stress

In addition to burnout and countertransference, compassion fatigue (CF) and Secondary Traumatic Stress (STS) are also used to describe the effects of trauma work on counselors. CF applies to anyone who suffers as a result of deep sympathy and empathy towards another who is suffering, it is often synonymous with STS (Devilly et al., 2009; Figley, 1995; Figley, 1999; Rothschild & Rand, 2006; Rudolph et al., 1997; Salston & Figley, 2003). STS is the emotional and behavioral reactions to having knowledge of a traumatic event experienced by a significant other. STS also includes the worry and strain one goes through in an effort to assist the traumatized individual. The STS response in a helping situation is considered natural, almost inevitable (Devilly et al., 2009; Dutton & Rubinstein, 1995; Figley, 1995; Figley, 1999). Counselors experiencing STS and CF are at risk of rendering impaired services and making poor professional judgments. Impaired services may include mis-diagnosising a client, ineffective treatment planning, or the potential abuse of clients (Rudolph et al., 1997).

STS symptoms mimic those of PTSD as outlined in the DSM-IV-TR (American Psychiatric Association, 2000) and discussed above; whereas PTSD is experienced by the individual exposed to the trauma, and STS is mere knowledge of the traumatic event and the event's impact on a significant other. Symptoms of PTSD include dreams and recollections of the event, an effort to avoid thoughts, activities or situations serving as reminders of the event, withdrawing from others, sleep disturbances, hypervigilance, and irritability (American Psychiatric Association, 2000). STS in counseling professionals includes similar symptomalogy (Chrestman, 1999; Figley, 1995). Chrestman (1999) found that counselors experienced "intrusive imagery related to the client's traumatic disclosures, avoidant responses, physiological arousal, other somatic complaints, distressing emotions, addictive or compulsive behaviors, and functional impairment" (p. 30).

Many factors contribute to potential reasons trauma workers are susceptible to the vulnerability of experiencing STS. First, in order to understand the traumatized person and their experience, the trauma worker often uses empathy. During the process of empathizing with a traumatized person, the helper may also be traumatized, thus potentially victimizing the counselor as a result of their connection. Second, it is likely that many trauma workers have personally experienced a traumatic event (Dutton & Rubinstein, 1995; Figley, 1995; Figley, 1999). Thirdly, counselors with a history of trauma who have not worked through their own process of recovery are susceptible to experiencing triggers activating those unresolved trauma issues. Similar issues may arise with clients and the counselor's own personal coping strategies; including environmental factors such as their support system, additional stressors in the helper's life, and the

climate in which the person lives and works may contribute to STS (Dutton & Rubinstein, 1995; Figley, 1995). Finally, children's trauma is often more provoking for therapists and helpers (Figley, 1995) further contributing to a counselor's experience of STS.

Valent (1995) states that STS responses often occur when the helper is impacted and influenced by the stress responses of the person directly exposed to the trauma. When these helpers are unable to implement their own coping skills, their reactions may wear into STS. When unable to cope, these helpers may begin to feel guilty or resentful, out of control, aggravated, and tired. In addition, helpers experiencing resentment, frustration, and STS may also experience feelings of survivor guilt, failure, and incompetence (Valent, 1995). According to Figley (1999) STS is emotionally exhausting, leaving the helper feeling confused, isolated, and helpless.

Vicarious Trauma

Similarities exist between STS and VT. As previously stated, STS is based in symptomology where the helping professional experiences symptoms mimicking those of PTSD. As with STS, VT also includes symptoms resembling those of PTSD. These symptoms include experiencing intrusive images of the traumatic event, avoidance reminders of the event, nightmares about client's trauma, withdrawing from others, an inundation of intense emotions, or a sense of unfeeling or numbness (Saakvitne & Pearlman, 1996). Other symptoms of VT include feeling little time or energy for oneself, feeling disconnected from loved ones, and withdrawing socially. Individuals with VT may also experience an increased sensitivity to violence, cynicism, and feelings of despair and hopelessness (Saakvitne & Pearlman, 1996). Finally, the psychological

factors most unique to VT include a disrupted frame of reference, changes in individual identity, changes in how one views the world, disrupted psychological needs and cognitive schemas, alterations in sensory experiences, diminished self capacities, and impaired ego resources (Saakvitne & Pearlman, 1996).

VT is the suffering and transformation of a counselor or helping professional resulting from empathic engagement with a client and hearing descriptions of a client's trauma (Pearlman, 1999; Rosenbloom et al., 1999; Rothschild & Rand, 2006; Saakvitne & Pearlman, 1996). However in addition to symptomology, VT also includes an alteration of the counselor's world view, belief system, and sense of safety, personal experience, and memories. This alteration occurs as a result of the counselor's exposure to the violence and horrors described by the client as a result of their experience with a traumatic event, and the cruelties one individual can inflict on another (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Salston & Figley, 2003). As with STS, VT is expected and unavoidable.

VT is described as changes in the therapist's cognitive schemas. According to Saakvitne & Pearlman (1996), "when we open our hearts to hear someone's story of devastation or betrayal, our cherished beliefs are challenged and we are changed" (p. 25). Part of the therapeutic process is the expectation that counselors and helpers listen to their clients with empathy. Through use of empathy, counselors and therapists are open and vulnerable thus exposing them to another person's trauma. They often hear graphic reenactments of the trauma in the therapy process and are exposed to the cruelty of others and the world (Bride, 2004; Pearlman & Saakvitne, 1995a, 1995b). Persons who do therapeutic work with victims and survivors of abuse, crime, war, rape, etc., may

experience profound psychological effects often mimicking symptoms of STS, however when these profound effects become disruptive and begin to impact the helpers personal sense of meaning, their view of the world, their perceptions of safety, and their perceptions of others, it is known as VT (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995a, 1995b). These changes in cognitive schema potentially impact a person's perceptions, world view, emotions, and relationships often leading to feelings of cynicism and distrust and potential feelings of vulnerability (McCann & Pearlman, 1990b; McCann & Pearlman, 1992; Trippany et al., 2003). Due to the inevitable and potentially permanent nature of VT it is important to discuss VT as it relates to counselors and therapists, its origins in the literature, its prevalence among helping professionals, and potential contributing factors, particularly a counselor's previous exposure to traumatic events.

Constructivist Self Development Theory

VT is grounded in constructivist self development theory (CSDT). CSDT is a personality theory derived from psychoanalytic and object relations theories, along with attributes of developmental cognitive theories and social learning theory. CSDT theoretically explains the impact of trauma on an individual's psychological development providing a framework for understanding trauma and its impact on counselors (Pearlman & Saakvitne, 1995a, 1995b). CSDT also claims the symptoms associated with VT are adaptations to events experienced. These adaptations or symptoms are grounded in the context of the event and the individual's perception of the event (Saakvitne & Pearlman, 1996).

CSDT implies that humans construct their own reality through cognitive structures referred to as schemas. Cognitive schemas are used to interpret events within a social and cultural context. These schemas develop and become more complex during an individual's lifetime. The cognitive schemas (or frameworks) that develop assist people in making sense of their world, themselves, their experiences, and their sense of self. The "self" is defined as an individual's identity, the way he or she relates to the world (McCann & Pearlman, 1990a; McCann & Pearlman, 1992; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996).

Individuals have ingrained beliefs about their personal safety, ways in which they protect themselves, and the predictability and control ability of situations; counseling trauma survivors tampers with these beliefs (Saakvitne & Pearlman, 1996). In addition to altering a counselor's beliefs, working with trauma survivors also alters the counselor's sense of self. CSDT identifies the parts of the self that are impacted by trauma and describes how they are affected. The five aspects of self are: Frame of reference, self capacities, ego resources, psychological needs and cognitive schemas, and memory and perception (Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996).

An individual's frame of reference is the foundation for who that individual is as a person, their sense of identity. This sense of identity, or inner experience, includes the individual's perception of self and their perceptions of others. This also includes their world view and spiritual beliefs. An individual's world view is their philosophy on life, their demeanor and convictions about others and the world in which they live. Their spiritual beliefs are their convictions of hope and faith, their personal values and morals. Spirituality is their ability to connect with something beyond themselves (Saakvitne &

Pearlman, 1996). The frame of reference embraces individual experiences and relationships with others and provides the lens for which one views the world, their interactions with others, and their experiences.

According to Saakvitne and Pearlman (1996) an individual's self capacities are their innermost ability to experience, endure, and integrate strong feelings. A person's aspect of self is molded by their ability to maintain inner balance, their ability to managing feelings, to feel they deserve life and love, to connect with others and know others care. Additional aspects of self include an individual's ego resources which are abilities that allow an individual to relate to others and meet their own psychological needs (Pearlman & Saakvitne, 1995a, 1995b). Counselors providing therapy to traumatized clients may find themselves struggling to maintain a sense of inner balance. They may be overwhelmed by feelings of anger, sadness, frustration, anxiety, or an inability to feel pleasure (Pearlman & Saakvitne, 1995a, 1995b).

Ego resources, as aspects of self, include decision making skills, self-awareness, setting healthy boundaries in interpersonal relationships, and working towards personal growth. Furthermore, when the counselor's ego resources are affected, they are more likely to make professional errors when working with clients. These may be errors in judgment, treatment strategies, or boundary setting (Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996).

CSDT postulates that humans have fundamental psychological needs which motivate behavior; the need for safety, dependency/trust, power, control, esteem, independence, and intimacy (McCann & Pearlman, 1990a, 1990b; McCann & Pearlman, 1992; Saakvitne & Pearlman, 1996; Trippany, et al., 2004). Direct or indirect exposure

to trauma can disrupt these schemas; the unique way that an individual experiences trauma will depend largely on which schemas are central to that individual. Disruption in cognitive schemas can also occur for counselors exposed to the traumatic experiences of clients. According to McCann and Pearlman (1990b), the counselor's reaction and response will also depend on which schemas are central to the counselor.

The need for dependency and trust is the ability to rely or depend on others to help meet individual needs. Through their clients, counselors working with survivors of trauma are exposed to the cruelty of society. They hear their client's experiences of how cruel, deceptive, and violating other human beings can be (McCann & Pearlman, 1990a, 1990b; McCann & Pearlman, 1992; Saakvitne & Pearlman, 1996). Counselors who have faith and trust in others may find their core values and beliefs changing especially if they continue to work with survivors of trauma, particularly victims of crime. Under these circumstances, therapists may begin to lack trust in others, they may become suspicious, and cynical (McCann & Pearlman, 1990b; Trippany et al., 2004). Counselors experiencing VT and struggling with their inability to trust others may begin to question their therapeutic effectiveness with clients.

Individuals also have the need to feel safe and free from harm. Counseling professionals exposed to images of others being harmed, may experience challenges to their own schema or perception of safety. As a result, the counselor might begin to feel vulnerable and question their own safety. They may have thoughts or visualizations of harm coming to themselves or their loved ones. Counselors who are experiencing VT may perceive either real or imagined threats to their own personal safety and believe they are unable to protect themselves (McCann & Pearlman, 1990a, 1990b; McCann &

Pearlman, 1992; Saakvitne & Pearlman, 1996; Trippany et al., 2004). Based on these beliefs, counselors may be extremely over protective and hyper-vigilant.

A person's sense of power derives from a need to have some control over others during interpersonal interactions as well as the ability to control one's own emotions and responses during these interactions (McCann & Pearlman, 1990a; McCann & Pearlman, 1992; Saakvitne & Pearlman, 1996). People who experience trauma through victimization often feel helpless, powerless, and vulnerable. Counselors exposed to such situations via a client's memories or recollections may be concerned about their own sense of power or potential loss of power. Counselors with a need for power are likely going to be impacted by their client's experience of powerlessness. Counselors may be left feeling helpless or depressed as they become aware of their powerlessness over violence (McCann & Pearlman, 1990b).

The human need for independence stems from the individual's need to be in control of their own behavior (McCann & Pearlman, 1990a; McCann & Pearlman, 1992). Survivors of crime related trauma, such as sexual assault, may experience a loss of independence or freedom; they may feel restricted and suffer a loss of autonomy. According to McCann and Pearlman (1990b), counselors who have a strong need or desire for independence, and identify with a client who has lost their sense of control and independence may be devastated by their client's experiences.

Esteem is the human need to be valued by others, to have one's self-worth validated by those around them (McCann & Pearlman, 1990a; McCann & Pearlman, 1992; Saakvitne & Pearlman, 1996). Individual need for esteem stems from the desire to view others as good and caring, and worthy of respect. Trauma survivors who have

experienced harm and violence at the hands of others may begin to lose their sense of esteem towards others and begin seeing all people as cruel and malicious. The counselor working with traumatized individuals may begin to question their own personal view of human nature and the benevolence of others. Exposure to this type of cruelty may leave the counselor feeling pessimistic and cynical (McCann & Pearlman, 1990b). In addition, counselors experiencing VT may feel inadequate and may begin to question their ability to effectively help someone (Trippany et al., 2004).

The final human need of intimacy is the human need to connect with ourselves, others, and our communities (McCann & Pearlman, 1990a; McCann & Pearlman, 1992; Saakvitne & Pearlman, 1996). Counseling professionals working with trauma survivors may begin to feel disconnected from co-workers, friends, and family as they are continuously exposed to horrific accounts of cruelty (McCann & Pearlman, 1990b). Counselors experiencing threats to their intimate connections or their ability to connect with others may avoid interacting with others, but feel void when they are alone, or finding a need to fill their alone time. Counselors may withdraw or push away others, or become too dependent on those close to them (Trippany et al., 2004).

If the needs and schemas of the counselor are challenged by the client's reported experiences counselors may begin to try and establish a frame of reference to understand the rationale behind the cruelty of others. In order to begin trying to understand these things, the counselor may first try to understand why an individual experienced a traumatic event. According to McCann and Pearlman (1990b), this frame of reference can become harmful and may be perceived as victim blaming.

In addition to changes in cognitive schema, VT also includes alteration of the memory system. Counselors with symptoms of VT may experience disruptions of the memory's imagery system. For example, counselors working with trauma survivors are exposed to in-depth accounts of the client's personal horrors and detailed accounts of abuse and other forms of victimization. After repeatedly hearing these graphic depictions, counselors may internalize the memories of their client's as their own, thus modifying their own memories either provisionally or eternally (McCann & Pearlman, 1990b).

Saakvitne and Pearlman (1996) describe memory and perception as "complex and multimodal" (p. 30). These authors state the act of processing and recalling memories and experiences happens cognitively, emotionally, visually, physically, and interpersonally. Trauma related images and memories include verbal accounts of the traumatic event and mental images of the event, as well as the emotions experienced before, during, and after the trauma. Additionally, processing and recalling traumatic memories also includes a recollection of the physical sensations and experiences as well as interpersonal patterns and behaviors within relationships.

Counselors who have internalized their client's traumatic memories may recall partial images that occur out of context with no related significance. These fragmented images may emerge as unwanted, intrusive thoughts, flashbacks or nightmares. When these images are most harmful to the counselor is when the traumatic image is related to the counselor's most prominent need areas (e.g., safety, independence, etc.; McCann & Pearlman, 1990b). It is suggested that the memories experienced by therapists that result from the memories recollected by their clients who have been traumatized, become

permanently incorporated into the counselor's memory system (McCann & Pearlman, 1990b).

VT also carries a social cost; whereas the cynicism and despair that accompanies VT is a loss of hope and the positive actions fueled by hope, for society. Rudolph et al., (1997) note that this loss can be "experienced by clients, as we at times join them in their despair; by our friends and families, as we no longer interject optimism, joy, and love into our shared pursuits; and which we may now leave, or withdraw from emotional in a state of disillusionment and resignation" (p. 33).

Factors that Contribute to Vicarious Trauma

VT is described as an inevitable, normal response to working with survivors of trauma; however there are various contributing factors. Factors contributing to VT include the distinct nature of the therapy process; including attributes of the client (e.g., self-destructive behaviors, despair, and suicidal thoughts), the context of both the therapy process, as well as the context of the trauma itself, cumulative exposure to trauma material, organizational context, social and cultural context, and supervision. Second, attributes and traits of the therapist, including vulnerabilities, the therapist's own personal history of trauma, their professional history, the meaning of traumatic life events to the therapist, psychological style and personality, interpersonal style, professional development and training, current stressors and coping styles, and personal therapy (McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Additional environmental factors play a role in how a counselor is able to manage the demands of their workload. For example, a person's social support, their access to counseling supervision, the size of their caseload

and the number of trauma survivors on that caseload (Kadambi & Ennis, 2004; Saakvitne & Pearlman, 1996).

Early research on VT supports many of the factors which contribute to VT stated above. Using the original Traumatic Stress Institute Belief Scale (TSI; as cited in Pearlman, 2003), now known as the TABS (Trauma and Attachment Belief Scale; Pearlman, 2003), Pearlman and Mac Ian (1995) discovered that trauma therapists with a personal history of trauma are impacted by VT (as measured by the TSI Belief Scale) more than those without histories of trauma. The authors caution others to avoid generalizing these results as the participants were self-selected and self-identified as trauma therapists; however this particular study is one of the most commonly referenced studies in the literature on VT.

Another commonly cited study by Schauben and Frazier (1995) provides results that contradict those found by Pearlman and Mac Ian (1995); specifically they found, among a population of trauma counselors working with survivors of sexual violence, that the counselor's own previous experience of trauma was not related to symptomatology of VT. However, this particular research used only the subscales of the TSI Belief Scale and provided a general description of VT asking participants to self-report their symptoms of VT. A more recent study by Trippany, et al. (2003) among a sample population of female counselors working with survivors of sexual assault (both adult and child), no relationship was found between a counselor's previous history of trauma and those working with adult survivors, however a relationship did exist between VT and a history of trauma for those counselors working with child survivors.

Additional research by Brady et al., (1999) found that among a sample of female counselors providing services to sexual abuse survivors, that these counselors exhibited more symptoms of trauma, but no disruption in cognitive schemas (the primary symptom of VT).

Each of these afore mentioned studies has a population sample of self-identified trauma counselors, three studies are specific to counselors working with survivors of sexual violence, and two studies focus on female counselors. These studies are limited in their sample populations and there are no comparison groups of non-trauma counselors, male counselors, or counselors who provide services to trauma survivors other than those survivors of sexual violence.

In addition to previous history of trauma, client caseload is also considered a contributing factor in VT. Chrestman (1999) found that an increase in trauma clients on a counselor's caseload was associated with an increase in VT symptoms; whereas other quantitative studies, such as the study by Baird and Jenkins (2003), do not support the theory that increased caseload is a contributing factor to VT. In fact the research results state that counselors with more clients on their caseload report less VT. The research by Baird and Jenkins (2003) focused on treatment providers who work primarily with survivors of sexual violence. The research by Baird and Jenkins is further limited as it focuses on STS, VT, and burnout as correlates rather than focusing primarily on VT.

Given the inconsistencies and limitations regarding the above described studies, recent concerns have emerged from the literature regarding VT. For example, Sabin-Farrell and Turpin (2003) assert that the counseling profession has embraced the concept of VT without continuing to conduct research which investigates or validates the concept.

It has also been suggested that the occurrence of VT among helping professionals has been exaggerated (Devilly et al., 2009; Kadambi & Ennis, 2004; Kadambi & Truscott, 2003; Sabin-Farrell & Turpin, 2003). In addition to concerns directly related to the frequency and prevalence of VT, there are also challenges in the area of assessing VT and its symptoms. There are discrepancies in the literature regarding the existence and pervasiveness of VT among professionals working with survivors of trauma where quantitative studies are not demonstrating an equal amount of support for the existence and occurrence of VT (Devilly et al., 2009; Kadambi & Ennis, 2004; Sabin-Farrell & Turpin, 2003). These discrepancies may be due to limitations in methodology and instrumentation.

Instruments used to measure symptoms of VT have significant limitations. The most common instrument used to measure VT is the TSI Belief Scale Revision L (Pearlman as cited in Pearlman, 2003). The TSI is used to assess cognitive disruptions in the five need areas outlined in CSDT. Use of the TSI continues to yield conflicting results in various studies (Kadambi & Ennis, 2004; Sabin-Farrell & Turpin, 2003). Additionally, many studies have assessed for VT using other instruments either in conjunction with the TSI Belief Scale (Brady et al., 1999; Devilly et al., 2009; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995) or without (Chrestman, 1999; Follette et al., 1994; Kassam-Adams, 1999) to measure symptoms associated with VT. Furthermore, there are no known current studies using the most recent version of the TSI, the TABS (Pearlman, 2003).

There are also limitations in methodology when assessing VT. Most of the research lacks control and comparison groups, which leads to poor validation. There is

also a failure to control for confounding variables (Devilly et al., 2009; Kadambi & Ennis, 2004; Sabin-Farrell & Turpin, 2003). One of these variables is the therapist's previous history of trauma. Some researchers have found that counselors with personal histories of trauma seem to have higher levels of VT (Kassam-Adams, 1999; Pearlman & Mac Ian, 1995). Other studies have failed to demonstrate a relationship between personal history of trauma and experience of VT (Schauben & Frazier, 1995; Trippany, 2001).

Research related to VT focuses generally on the impact of trauma work on counselors using instruments that measure symptoms of burnout and STS in conjunction with VT. In fact, a recent study by Devilly et al., (2009) found STS, VT, and burnout to be highly convergent constructs. Furthermore, they found a high correlation between VT and burnout more so than STS and VT, concluding that the three constructs actually measure the same phenomenon, burnout. Their findings contradict the theories postulated by Figley, Pearlman, and Saakvitne and support general criticisms regarding the existence and prevalence of VT.

After a thorough review of the literature, it appears as if the original, theoretical works on VT have been considered fact (Bride, 2004) without additional studies to confirm the existence of VT. This particular study will attempt to identify the prevalence of cognitive changes associated with VT among counseling professionals providing services to clients with a range of trauma related experiences.

Additionally there are limitations in instrumentation when measuring VT and an individual's history of trauma. This study will specifically use the TELQ to measure an individual's history of trauma and the most recent up to date version of the TABS to measure VT. Furthermore, many studies also measure VT while comparing it to other

constructs such as, Burnout, CF and STS, and PTSD. This particular study will only focus on the construct of VT and the cognitive changes associated with it.

Finally, this study will further attempt to clarify some of the more perplexing factors that contribute to the existence of VT such as gender and the counselor's history of trauma. No known studies focus solely on VT and the counselor's history of trauma as measured by the TLEQ. Additionally the type of trauma experience has not been categorized and compared to VT. Use of the TLEQ will not only provide information regarding a counselor's history of trauma, but will also provide information on the type of trauma experience. Perhaps it is not just a person's history of trauma that contributes to their experience of VT, but the type of trauma they have experienced. Furthermore, some studies have limited their participants to females only, yet no known studies address gender as a contributing factor. This study will pool from a sample of male and female counselors and will also include a comparison group of non-trauma workers.

CHAPTER III

METHODOLOGY

This chapter delineates the participants, procedures, research design, instruments, data analysis, and hypothesis tested in this study.

Participants

The target populations for this study were practicing counselors, counseling psychologists and clinical social workers holding the equivalent of a Master's degree or higher in their related field of study. Participants for this study were recruited from mental health agencies, private practice, victim advocacy settings and college counseling centers. Participants were counselors with experience working with clients from various backgrounds and clients with a range of exposure to traumatic events. Participants displayed a range of personal trauma experiences from limited or no exposure to repeated and intense exposure.

Volunteer participants were not excluded from participation in this study based on their race, gender, gender identification, sexuality, religious preference, or ethnicity. Participants were excluded from the study if they did not meet the educational and professional requirements by holding a Master's degree in counseling, psychology or social work. Participants were purposefully selected from a voluntary, convenience based sample.

A minimum of 114 participants were recruited for this study. This number was determined to be the minimum number necessary for a valid T-test and Multivariate Analysis of Variance (MANOVA) to be conducted during statistical analysis of the data. Using the statistical software, G. Power (Faul, Erdfelder, Buchner & Lang, 2009; Faul, Erdfelder, Lang, & Buchner, 2007) with a recommended ($\alpha = .05$) level of significance, a large effect size of .4, and a fixed power of .9 it was determined that 114 participants were necessary.

Participants were selected based on their level of education (Master's degree or higher) and their professional training as counselors, counseling psychologists or clinical social workers. Participants self-reported their level of education, professional training, gender, caseload information, and their own personal history of trauma and counseling on the demographics questionnaire (see Appendix A). Participants were also asked to disclose personal experiences which may be perceived as traumatic and the type of experience (i.e., natural disaster, transportation accident, war, interpersonal violence, intimate partner abuse, illness or death, and child abuse), and their symptoms of vicarious trauma (VT) via survey instruments.

Participants were drawn from a purposeful and convenience based sample of professional counselors, counseling psychologists and clinical social workers and identified via multistage clustering (Creswell, 2009). Participants were recruited in one of three ways; via identified organization, by referral, or from a flyer posting. Initially the researcher identified organizations, agencies, and counseling centers providing counseling services to clients then mental health professionals were recruited voluntarily as participants, from within. Organizations providing professional counseling services

within the Rocky Mountain Region (which includes the States of Colorado, Idaho, Montana, New Mexico, Utah, and Wyoming), were identified and agency administrators were distinguished and solicited via phone and email. Administrators were provided a description of the study, the consent for agency participation form (Appendix B), the participant informed consent (Appendix C) and a recruitment flyer to be distributed electronically or posted in a location of their choice (Appendix D).

Administrators who offered agency participation were contacted via phone or email and the researcher and administrator determined a convenient date and time for the researcher to be on-site. The researcher was often offered a conference room within the agency to administer the instruments to multiple participants in a group setting, on other occasions the researcher met with participants in their private, confidential offices.

In addition to coordinating with large agencies and counseling centers individuals in advocacy settings and private practices settings were also invited to participate. Many independent participants were either referred by another volunteer participant or contacted the researcher directly via phone or email in response to a flyer or posting. Flyers were posted to counseling list serves such as those affiliated with Colleges and Universities as well as those maintained by professional counseling organizations. When contacted by these potential participants the researcher sent a follow up email which included brief description of the study which included the requirements for participation, the informed consent, and a copy of the recruitment flyer for their review and consideration. If the participant met the professional and educational requirements the researcher and participant then agreed upon a date, time, and location convenient to the participant to administer the surveys. When meeting with individuals who were not

members of an agency the researcher consented to meet with participants at a location of their choice, the most common location was a Starbucks Coffee shop near their work or home.

The researcher, in exchange for voluntary participation, offered participating organizations and volunteers a1 hr training on the topic of VT and counselor impairment. The training was offered on two separate dates, one was scheduled onsite at the University of Northern Colorado the other training was in webinar format. Participants who were not available to attend either training date were provided a link to the recorded webinar to view at their convenience. Additional incentives offered to participants included the opportunity to win one of three $50 gift cards to Amazon.com which was raffled off at the end of the data collection process. Once the data collection process was completed all raffle entries were placed into a large manila envelope and three names were drawn by the research advisor participation in the raffle was voluntary.

Once the preferred method of recruitment was established, volunteer participants identified, and informed consents sighed then professional counseling staff with a Master's Degree or higher in counseling, psychology, or social work were invited to voluntarily complete the self-reported demographics questionnaire, the Traumatic Life Events Questionnaire (TLEQ; Kubany, 2004), the PTSD Screening and Diagnostic Scale (PSDS; Kubany, 2004) and the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003).

Research Design

The research design for this study was survey-based research which examined differences between subjects and made explanatory assertions about counseling

professionals and their experience of VT (Babbie, 1990; Babbie, 1995; Creswell, 2009; Fowler, 1993). Survey method was chosen to gather quantitative information from a sample of counseling professionals regarding their personal experience of trauma and to identify symptoms of VT present in the sample population. Additionally, survey method was chosen to examine what type of relationship or patterns existed between different categories of trauma (i.e., interpersonal violence, natural disasters, transportation accidents, child abuse, intimate partner violence, death and loss, and war) and the degree to which VT was experienced. For this particular study, survey method was the most desired because there were minimal costs, a minimal time commitment for participants, and standardized questionnaires were available to measure the concepts of interest.

The survey was cross-sectional (Babbie, 1990; Creswell, 2009; Lewin, 2005) and participants completed each instrument in one sitting, additional meetings for data collection or follow up were not necessary. Data were collected through self-administered questionnaires and scored by the researcher. The instruments were issued in the following order; the demographics questionnaire (to confirm the participant's level of education and professional experiences), the TLEQ (which identified the participant's history of trauma; Kubany, 2004), the PSDS (which determined any PTSD symptoms related to their trauma history as identified by the TLEQ; Kubany, 2004), and the TABS (which identified any changes in their beliefs which may be a result of their history of trauma or their clinical work with clients; Pearlman, 2003). The PSDS must be administered after the TLEQ as the symptoms reported on the PSDS directly related to the experiences reported in the TLEQ (Kubany, 2004). Although order effects are a

consideration with survey research, the Trauma Assessment Inventories (TLEQ and PSDS) require the survey administration be fixed in the order stated above.

Upon completion of the demographics questionnaire, TLEQ, PSDS (Kubany, 2004), and TABS (Pearlman, 2003) participants were provided an Institutional Review Board (IRB) approved handout which briefly provided information on trauma related stress and symptoms of PTSD (see Appendix E) and a list of three online resources which could aid the participant in identifying mental health providers in their local community (Appendix F). The purpose of these handouts were to debrief participants about trauma exposure and the potential individual responses to trauma as well as assist in identifying available counseling resources in their community. Participants received the debriefing handout and resource list as a precautionary measure in the event they experienced some level of emotional discomfort related to the survey instruments.

Procedures

For the purpose of replicating this study, the following procedural steps were taken: First, an application was submitted to the IRB for consideration of the ethical treatment of participants and was approved (see Appendix G). Upon approval from the IRB, the researcher began to recruit participants. Participants were recruited from mental health agencies, university counseling centers, victim advocacy centers, and private practitioners from a convenience sample. Participants received an initial phone call or email inviting them to voluntarily participate in the study, if interested a follow up email was sent which described the study and included the agency permission form, if applicable, and the informed consent forms. Participants who emailed the researcher directly offering their voluntary participation received the same information.

Once agency directors were contacted and consented to participation, methods of recruitment were established, and a date and time were determined, potential participants received information regarding the date and time of the study and an email which included the informed consent. For non-agency participants, once they were contacted by phone or email, and the informed consent was reviewed the researcher scheduled a time to be on-site to administer the surveys (participants who would prefer their surveys be mailed specified a mailing address at this time). Only one participant requested their survey be mailed. Once on site the researcher reviewed the informed consent and answered any questions participants had about the informed consent or survey instruments, after which the participant signed the informed consent and agreed to participate.

After the consent form was reviewed and signed, the participant completed the demographics questionnaire, the TLEQ (Kubany, 2004), the PSDS (Kubany, 2004), and the TABS assessment (Pearlman, 2003). Participants volunteered anywhere between 20 and 40 minutes of their time for this study.

In an effort to maintain participant confidentiality participants were not asked to provide any identifying information on their survey assessments other than the demographic information provided on the demographics questionnaire. Once the assessments were completed the participant was given the debriefing letter and accompanying resource list. Participant score sheets were placed in a manila envelope and the envelope was sealed, no identifying information was provided on the envelope. To continue ensuring participant confidentiality, informed consent forms were kept separately from completed survey assessments. The envelopes containing survey

assessment responses and separate informed consent forms were placed in a locked traveling file box and locked in the researcher's car for transportation to a secure, confidential location. The confidential location where informed consents and raffle slips were kept was a locked file cabinet in the office of the research advisor located at the University of Northern Colorado; all survey responses were kept in the researchers home until data collection and results were completed, they were then transferred to a locked file cabinet at the University of Northern Colorado. Records will be stored for five years following any publications that may arise from the completed dissertation study (American Psychological Association, 2010).

Variables

As previously stated, the purpose of this study was to identify if mental health professionals' personal history of trauma, or lack of, contributes to experiencing VT and to identify if the type of trauma experienced by the mental health professional influenced the degree to which VT was experienced. In addition, this study determined if gender and the number of trauma clients per caseload were also contributing factors to VT. The independent and dependent variables measured and discussed are reported below.

The dependent variable in this study was VT, measured through the TABS. The independent variables measured and analyzed for this study were (1) mental health practitioner's previous experience of traumatic events, measured by the TLEQ and PSDS; (2) The type of traumatic event(s) experienced by the counselor, measured by the TLEQ, (3) the counselor's gender (as reported on the demographics questionnaire) and (4) the percentage of clients on their caseload with histories of trauma (as reported on the demographics questionnaire).

Instruments

Demographics Questionnaire

After participants voluntarily consented to participate they were asked to complete a demographics questionnaire designed by the researcher for the purpose of gathering information specific to this study. The questionnaire included demographic information regarding the participant's gender, age, ethnicity, and state of residence. The questionnaire did not ask for the individual's name in order to protect their anonymity. The questionnaire also included questions regarding the participant's professional experience; the number of clients who were receiving services on the participant's caseload and the percentage of those clients with traumatic histories. Additionally, the demographics questionnaire asked participants about their own personal histories of trauma and experiences with counseling.

After completing the demographics questionnaire participants were asked to complete the Traumatic Life Events Questionnaire (TLEQ; Kubany, 2004). The TLEQ is one of three instruments included with the Trauma Assessment Inventories. The inventories are typically used to understand, screen and diagnose traumatic experiences and responses. The assessment inventories used for this student were the TLEQ, which is considered a screening instrument for trauma and the PSDS which was used to assist in the diagnosis of PTSD. Together, the TLEQ and PSDS were used to identify a history of trauma and screen for the presence of PTSD (Donnelly & Donnelly, 2007; Kubany, 2004; Sheperis & Heiselt, 2007). The TLEQ has been used in previous research to assess for trauma history (Alvarez, et. al., 2009; Oyefeso, Brown, Chiang, & Clancy, 2008). Additionally, when compared to a structured clinical interview (SCI) to assess for trauma

history, the TLEQ had a higher rate of reported traumas than the SCI (Peirce, Burke, Stoller, Neufeld, & Brooner, 2009). The PSDS accompanied the TLEQ as a follow up assessment for symptoms of PTSD.

Of the three instruments available in the Trauma Assessments Inventories, the TLEQ was used to identify the most distressing event and the PSDS was designed to screen for PTSD symptoms related to the event identified by the TLEQ. The inventories also include the Trauma-Related Guilt Inventory (TRGI), an assessment often used during treatment or cognitive therapy to explore feelings of guilt in trauma survivors (Donnelly & Donnelly, 2007; Kubany, 2004; Sheperis & Heiselt, 2007). This third measure was not used for this study as it was considered optional and was not related to the variables of interest.

Traumatic Life Events Questionnaire (TLEQ)

After an extensive review of trauma instruments it was determined that the TLEQ was the most appropriate survey instrument for this study as it addressed the history of trauma variable under review. For the purpose of this study the TLEQ was used to identify the participants' previous exposure to trauma, the types of traumas they had experienced, the frequency with which they experienced each traumatic event, and the event which caused them the most distress (Kubany, 2004). It is important to note that the TLEQ was a self-reported instrument so participant reports of trauma exposure could not be verified. The TLEQ consists of 24 items, and is a paper and pencil, brief structured self-report instrument often used in the clinical setting to gather information about a person's trauma history. The assessment took participants approximately 15-20

minutes to complete and was written at a sixth grade reading level according to the Flesch Grade Level (as cited in Kubany, 2004).

Items in the TLEQ were related to potentially traumatic events such as automobile accidents, war, the unexpected death of a friend or family member, intimate partner violence, abuse, and other similar events. Item 23 asked participants to identify any other event they may have experienced not listed in questions 1-22 and the final item asked participants to indicate which event was the most distressing to them and how much anxiety the event caused (Donnelly & Donnelly, 2007; Kubany et al., 2000; Kubany, 2004; Sheperis & Heiselt, 2007). Responses to the TLEQ items were later used to determine if a relationship existed between the traumatic experiences a participant has personally been exposed to and their experience of VT.

Items on the TLEQ asked questions related to different types of traumatic events. The questions were displayed in order from least personal to most personal (Kubany, 2004). For example, the questionnaire began by asking about natural disasters and accidents, and then it gradually progressed to questions about serious bodily injury and ended with questions regarding physical and sexual abuse. The more personal questions asked the participant to confirm any history of family violence or abuse (i.e. “while growing up did you see or hear family violence?” Kubany, 2004, p. 5). Some questions, regarding threatened harm, asked the participant if the person who harmed them was “a stranger? A friend or an acquaintance? A relative? An intimate partner?” (Kubany, 2004 p. 5) followed by a yes or no response. The items described events in behavioral terms that matched professional definitions of these events as they are described in the literature (Kubany, 2004).

Use of specific terms, such as rape or domestic violence, were avoided as they may cause strong, emotional responses which may be based in stereotypical beliefs (Kubany, 2004). TLEQ items also asked about the frequency with which the traumatic events occurred. Respondents were asked if the given event ever happened, and if it did, if it happened once, twice, 3 times, 4 times, 5 times, or more than 5 times. Respondents were also asked if they had experienced intense fear, helplessness, or horror during the events (Kubany, 2004). The final two questions asked participants to identify any other traumatic event they may have been exposed to that was not addressed in the other 22 questions and which events addressed in the questionnaire caused them the most distress (Kubany, 2004).

A sample question from the TLEQ is as follows (item 8): "Have you been robbed or been present during a robbery in which the robber(s) used or displayed a weapon?" (Kubany, 2004). Response options to this question are "yes or no, if yes how often? Once, twice, 3 times, 4 times, 5 times, or more than 5 times? If this happened: did you experience intense fear, helplessness, or horror when it happened, yes or no? And, were you seriously injured, yes or no?" (Kubany, 2004, p. 5). Due to the nature of the questions and that recalling these experiences may have caused anxiety and distress, Kubany (2004) recommends the administrator of the instrument always conduct some form of debriefing after the TLEQ is completed. A sample handout was provided in the manual and a modified version of this debriefing form was provided to participants upon completion of the assessments along with additional resources for care.

The TLEQ did not produce standard scale scores, as a result the psychometric analysis focused on temporal consistency (the reliability of an individual's response) and

content validity. Items for the TLEQ were developed from a thorough review of the literature on PTSD and traumatic stress, a review and comparison of other instruments, and consultation and evaluation by experts in trauma and PTSD. Expert reviewers were asked to evaluate the relevance of the TLEQ items and how well the items represent traumatic experiences (Donnelly & Donnelly, 2007; Kubany, 2004; Kubany et al., 2000; Sheperis & Heiselt, 2007). For this study an MANOVA was used for statistical analysis and the categories of trauma were created by the researcher. Additionally, the yes or no responses were assigned a numerical value. Furthermore, the number of traumas a person had experienced were also assigned a numerical value.

To evaluate test-retest reliability for reports of occurrences and non-occurrences of trauma exposure (as described in the TLEQ) four studies, with four different populations were conducted over varying intervals from five days to two months (Kubany, 2004). The four different populations studied were: 51 Vietnam combat veterans; 49 individuals in a residential substance abuse program; 62 college students; and 42 women attending support groups for domestic violence (Donnelly & Donnelly, 2007; Kubany et al., 2000; Kubany, 2004; Sheperis & Heiselt, 2007).

Each item was assessed with percent agreement and Cohen's kappa (Donnelly & Donnelly, 2007; Kubany et al., 2000; Kubany, 2004; Sheperis & Heiselt, 2007). Results of these four studies indicated that "most items possess adequate to excellent temporal stability" (Kubany, 2004, p. 8). The items with the strongest temporal stability referenced intimate events (e.g., abuse or violence) whereas the item with the poorest temporal consistency referenced accidents. Among the studies conducted the percent agreement for test-retest reliability ranged from 63% to 98% for some items among the

different sample populations, with kappa coefficients ranging from .27 to .80 (Kubany, 2004).

Overall, the TLEQ appeared to accurately measure an individual's exposure to various events which may have been perceived as traumatic. The frequency of exposure to the event was also addressed as well as the level of distress and anxiety exposure to such events may have caused.

For this study the traumatic events identified in the instrument were assigned to one of six categories; natural disaster, accident, illness or death of a loved one, interpersonal violence, intimate partner violence, and abuse. When participants responded 'yes' to any of the questions in the TLEQ the researcher assigned those responses to one of the six categories created by the researcher. The following categories correspond to the following questions: natural disaster, question 1; accident, questions 2 & 3; illness or death of a loved one, questions 5, 6, 7, 21, & 22; interpersonal violence, questions 4, 8, 9, 10, 11, 18, 19, & 20 (if the perpetrator was not an intimate partner in questions 11 & 18); intimate partner violence, questions 11, 14, & 18, (if the perpetrator was an intimate partner in questions 11 & 18); abuse, questions 12, 13, 15, 16, & 17).

Post Traumatic Stress Disorder Screening and Diagnostic Scale

The PSDS was a 38 item self-report questionnaire used to identify symptoms of PTSD as they related to the traumatic experience reported in question 24 of the TLEQ (Donnelly & Donnelly, 2007; Kubany, 2004; Sheperis & Heiselt, 2007). The PSDS was formally known as the Distressing Event Questionnaire (DEQ) (Kubany, Leisen, Kaplan,

& Kelly, 2000). Items on the PSDS assessed for PTSD based on the six criteria listed in the DSM-IV (American Psychological Association, 2000).

Described briefly, the six criteria for PTSD are: (A) exposure to a traumatic event (either experienced or witnessed and accompanied by death or the threat of death and feelings of intense fear, helplessness, and horror, (B) the traumatic event continues to be relived either through nightmares, intrusive thoughts, or feeling as if the event were happening again even in the absence of cues related to the event. Criterion C) includes the avoidance of anything related to the trauma, inability to remember parts of the trauma, feeling detached, as well as a lack of interest or enjoyment in things that were once enjoyable. Criterion (D) consists of increased arousal as evidenced by increased alertness, disturbances in sleep and concentration, and feelings of irritability, (E) the symptoms described above last longer than 30 days and (F) cause distress and impairment in functioning (American Psychiatric Association, 2000).

Items on the PSDS asked respondents if the symptoms had been present for more than 30 days, when they first occurred, and how long the symptoms lasted (Kubany, 2004). Eleven items asked about distress and functioning in areas of social life, personal relationships, work, and religion. For example, participants were asked to scale (0 – 4, where 0 is no negative effect and 4 is negative effects to an extreme or severe degree) how much the traumatic experience had impacted their social life, relationships and other aspects of their life (Kubany, 2004). Additional items addressed guilt and anger related to trauma and loss. The PSDS was designed to be used in conjunction with the TLEQ to assess trauma history and screen for PTSD. It is important to note that alone, the PSDS should not be the sole assessment to determine a diagnosis of PTSD (Kubany, 2004).

The PSDS was written at an eighth grade reading level and was recommended for individuals over the age of 18. Combined with the TLEQ, the instruments tooke less than 20 minutes to complete (Donnelly & Donnelly, 2007; Kubany, 2004; Sheperis & Heiselt, 2007). Items were rated on a 5 point Likert scale ranging from "absent or did not occur" to "present to an extreme or severe degree." Participants were asked to circle the number (Likert rating) that best described the intensity to which they have had each experience during the past month. For example, question number (5) "Bad dreams or nightmares about the event(s)"; 0-absent or did not occur, 1-present to a slight degree, 2-present to a moderate degree, 3-present to a considerable degree, and 4-present to an extreme or severe degree (over a 30 day period; Kubany, 2004).

Content validity for the PSDS was established through a review of all items on the PSDS by an expert-review panel of clinical specialists in the area of PTSD (Donnelly & Donnelly, 2007; Kubany, 2004; Sheperis & Heiselt, 2007). Reliability of this instrument was established by determining the internal consistency of symptom reports among the 20 items addressing symptomalogy on the PSDS, alpha coefficients for test-re-test correlations, and temporal stability in terms of diagnosis based on PSDS score (Donnelly & Donnelly, 2007; Kubany, 2004; Sheperis & Heiselt, 2007).

To determine internal consistency for the PSDS, Vietnam combat veterans and four groups of women who had experienced sexual abuse, sexual violence, intimate partner abuse, and women with histories of substance use and prostitution completed the PSDS. Alpha coefficients for criterian B, C, and D among these groups ranged from .83 to .98 (Kubany, 2004; Sheperis & Heiselt, 2007). Test-retest reliability was assessed with 52 Vietnam combat veterans and 54 women receiving services for domestic

violence. For the overall scale test-retest correlation scores were .95 and .83 were calculated. Coefficient alpha estimates were above .80 for all clusters of PTSD symptoms indicating strong internal consistency (Donnelly & Donnelly, 2007; Kubany, 2004; Sheperis & Heiselt, 2007).

Validity of the PSDS was examined in homogeneous populations (trauma populations) and heterogeneous populations (utility of the PSDS in conjunction with the TLEQ), to assess the symptoms and severity of PTSD (Kubany, 2004). Accuracy of a PTSD diagnosis was studied by comparing PSDS responses to responses on the Clinician-Administered PTSD scale, the Penn Inventory, BDI, Cook, Medley Scale and the Rosenberg Self-Esteem Scale (as cited in Kubany, 2004). The manual provided detailed tables which included accuracy and correlations indicating strong evidence of discriminant validity and convergent validity (Donnelly & Donnelly, 2007; Sheperis & Heiselt, 2007).

When scoring the PSDS individuals either met the requirements for Criterion A, B, C, D, E, and F or they did not. In addition to each individual criteria assessed, the PSDS provided a total score for PTSD symptomology. A score of 0-17 on the PSDS indicated no PTSD or only mild symptoms, 18-39 suggests mild to moderate symptoms, 40-49 suggests moderate to severe symptomology, and 50-60 indicates severe symptoms (Kubany, 2004). The total score provided on the PSDS was the score used to measure PTSD symptoms in this study.

Trauma and Attachment Belief Scale (TABS)

The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003), formerly the TSI (Traumatic Stress Institute Belief Scale) was an 84-item self-report, questionnaire

created to assess the impact traumatic experiences have on an individual's cognitive schemas. The instrument was founded in Constructivist Self Development Theory and created to assist clinicians and researchers in understanding the complexity and pervasiveness of an individual's traumatic life experiences (Pearlman, 2003). The initial instrument was created in 1988 and was named the McPearl Belief Scale. The subscales on the McPearl Belief scale were amended and adjusted accordingly and were eventually separated based on the five need areas (outlined in CSDT) into additional subscales consisting of self and others. According to Pearlman (2003) the modified version of the McPearl Belief scale was renamed the TSI Belief Scale (Traumatic Stress Institute) in 1991 and the most current version, (the version used in this study), is the TABS.

As mentioned previously the TABS was based on CSDT (McCann & Pearlman, 1990b). The TABS subscales related to the five psychological needs identified in the theory (Aidman, 2007; Garro, 2007; Pearlman, 2003). For each of these five needs, there are beliefs about self and beliefs about others. For example, an individual who is the victim of interpersonal violence or crime may have a stronger need for safety after the crime than before. Additionally, the perceived safety of their loved ones may also change as a result of their traumatic experience.

The TABS has 10 subscale scores (five need areas related to self, five need areas in relation to others) and a total score. Raw scores were calculated for each item and for the ten sub scales which were then converted into standard scores (normalized T-scores and percentile ranks; Aidman, 2007; Garro, 2007; Pearlman, 2003). All of the TABS item responses were based on a Likert scale ranging from 1-6 (1 = Disagree strongly, 6 = Agree strongly; Aidman, 2007; Garro, 2007; Pearlman, 2003). Items on the instrument

were written at a third grade reading level according to the Flesch Reading Ease scale (Pearlman, 2003) and it took participants between 10 and 20 minutes to complete.

Internal consistency and test-retest reliability estimates for the TABS were calculated from a sample of 260 college students. The estimated internal consistency was .96 with a test-retest correlation of .75 for the total score. For the subscales a median internal consistency estimate of .79 was obtained. Subscale values ranged from .67 for the Self-Intimacy subscale to .87 for the Other-Intimacy subscale (Aidman, 2007; Garro, 2007; Pearlman, 2003). Test-retest reliability for the same sample of college students was administered on an interval of 1-2 weeks. The test-retest reliability for the TABS subscales ranged from .60 for the Other-Intimacy subscale to .79 for the Other-Trust subscale (Aidman, 2007; Garro, 2007; Pearlman, 2003). Pearlman (2003) stated the reason for low internal consistency estimates for the Self-Intimacy subscale is offset by good test-retest reliability and factor analysis which supported maintaining this as a subscale.

Validity for the Tabs was established with evidence of face validity, construct validity, and criterion validity (Pearlman, 2003). Items on the TABS demonstrated face validity because they specifically asked about individuals' beliefs regarding safety, trust, esteem, intimacy, and control, which was the purpose of the instrument (Pearlman, 2003). Construct validity for the TABS was determined by experts who reviewed items during the development of the assessment. Each reviewer assigned an item to a need area, if all reviewers did not agree the item was removed. Additionally, construct validity for the TABS was assessed using correlations with other test results, interscale correlations, and factor structure (Pearlman, 2003).

In an effort to determine construct validity for the TABS, the TABS was compared to another instrument which measures symptoms of trauma (The Trauma Symptom Inventory; TSI). In a sample of 207 outpatients with chronic disturbances, described as depression, sexual concerns, dissociated behavior, etc., the total score for the TABS strongly correlates with the following scores on the TSI; impaired self-reference, dissociation behavior, and depression (Pearlman, 2003). Strong subscale correlations between the TABS and TSI support construct validity for this instrument.

Additional methods were used to further determine construct validity. Intercorrelations from two sample populations were used; the standardization sample of 1743 adults and a nonclinical sample of 262 college students. Findings showed evidence that the subscales were highly intercorrelated with the TABS total score ranging from .66 - .88, but not highly intercorrelated with each other (Aidman, 2007; Garro, 2007; Pearlman, 2003).

The final method used to determine construct validity was factor structure. Factor structure was used with the subscales demonstrating a relationship between the items for the non clinical sample of 262 college students. Factor structure supports a strong relationship between Other-trust and Other-esteem subscales and a strong uniqueness for the subscales of Other-intimacy and Self-intimacy.

In an effort to identify a relationship between the TABS scores and an individual's status as it relates to certain criterion measures (criterion validity), a sample of 201 outpatients were used and the mean TABS scores were identified (Pearlman, 2003). The groups identified for this sample were outpatients with no history of trauma (n=22) with a mean score of 54.6, outpatients with a history of trauma (non-child abuse)

with a mean score of 61.7, and outpatients with a history of child abuse with mean score of 66.5 (Pearlman, 2003). Results showed higher TABS scores for participants with a history of trauma than those with no history and higher TABS scores for participants with a history of child abuse versus other traumas and those with no history of trauma (Pearlman, 2003).

For the purpose of this study, the TABS was used to assess for VT in counseling professionals. Use of this instrument for the purpose of identifying VT was supported in the TAB's manual. Pearlman (2003) cites several research studies where the TABS has been used to assess for VT. For example, in the studies by Schauben & Frazier (1995) and Pearlman and Mac Ian (1995) the TABS (formerly TSI) was used to assess for VT (Pearlman, 2003). Other studies using the TABS cited by Pearlman (2003) include a study by Brady et al., (1999), Cunningham (1997; as cited in Pearlman, 2003), and Galloucis (1995; as cited in Pearlman, 2003). Overall, the TABS demonstrated reliability and validity in its ability to measure disruptions in cognitive schemas related to the five need areas of control, safety, intimacy, esteem, and trust and was appropriate for use in this study.

The TABS provided T-scores for each subscale or need area and a total T-score to indicate the level of disruption in an individual's need area where a higher score indicates relative disruption and a lower score indicates a relief from disruption. T-scores less than or equal to 29 indicate extremely low or little disruption, T-scores between 30-39 are very low, scores between 40-44 are low average, scores between 45-55 indicate average disruptions, scores between 56-59 are high average, 60-69 very high, and T-scores greater than or equal to 70 are extremely high and indicate major disruption. The total

TABS T-score was the score used to measure VT for the purpose of this study (Pearlman, 2003).

Research Design and Hypothesis

This study addressed four research questions to determine contributing factors to VT. Descriptive statistics were used to describe the sample population. Mean and mode were used to identify the sample size by age, and the numbers of clients per caseload with a history of trauma. Statistical Package for the Social Sciences, version 18 (SPSS) was used to calculate all statistical measures.

Q 1: Is there a relationship between a mental health professional's history of trauma, symptoms of PTSD, and their experience of vicarious trauma?

H1 It was hypothesized that a relationship would exist between an individual's history of trauma and their experience of VT. It was anticipated that individuals with histories of trauma would experience higher levels of VT than those without trauma histories.

H2 It was hypothesized that counseling professionals with symptoms of PTSD were more likely to experience VT than those with no symptoms.

The statistical method used to determine if a relationship existed between an individual's history of trauma and their experience of VT was a Pearson Correlation Coefficient. The independent variable (IV) in this case was the mental health professional's history of trauma which was measured with the TLEQ scores. The dependent variable (DV), vicarious trauma, was measured with the TABS scale. An additional alternate hypothesis asserted that counselors with symptoms of PTSD would be more likely to experience VT than those with no symptoms. This was also measured with a correlation coefficient. The independent variable was symptoms of PTSD (as scored by the PSDS), and dependent variable was vicarious trauma as measured by the TABS.

Q 2: Is there a difference between the categorical type of trauma (ie: natural disaster, intimate partner violence, child abuse, interpersonal violence, accident, and death or illness) experienced by a counselor and their experience of VT?

H3 It was hypothesized that a difference would exist between the type of trauma experienced by an individual and their experience of VT. It was anticipated that individual's with more severe traumas (interpersonal violence, child abuse, war, and intimate partner violence) would be more likely to experience VT.

The statistical method used to determine if there was a difference in the type of trauma exposure and vicarious trauma was Multivariate Analysis of Variance (MANOVA). Wilks' Lambda multivariate analysis was performed to identify variance among the categories. The IV's measured were the six categories of trauma and the DV was vicarious trauma. The instruments used to determine this comparison were the TLEQ and the TABS.

Q 3: Are there gender differences in the frequency in which VT is experienced?

H4 It was hypothesized that more women would experience VT than men. It was also anticipated that the percentage of female participants in this study would be greater than that of male participants.

The statistical method used to determine if there was a difference between genders was a t-test. The instruments used to determine this were the demographics questionnaire (to identify participant's gender) and the TABS to measure VT.

Q 4: Is there a relationship between the number of clients with histories of trauma on a counseling professional's client caseload and the counseling professional's experience of VT?

H5 It was hypothesized that a high caseload of clients (as defined by the participant) with histories of trauma would contribute to a counseling professional's experience of VT.

A correlation coefficient was the statistical method used to determine if a relationship existed between a counselor's caseload and VT. The instruments used were

the demographics questionnaire (which identified the number of clients on a caseload) and the TABS (which identified VT). The independent variable was the counseling professional's caseload and the dependent variable was VT.

Conclusion

In summary, this study attempted to assess counselors for symptoms of VT and to identify factors which may contribute to these symptomalogy. More specifically, survey assessment and quantitative analysis were used to identify if a relationship exists between counselors with a history of trauma and symptoms of VT. Survey method and quantitative analysis were also used to distinguish between the type of traumatic experience in a counselor's history and their experience of VT. Finally, the same methodology was used to determine if gender and client caseload were also contributing factors.

CHAPTER IV

ANALYSIS

This chapter provides detailed information regarding participant demographics, assessment results and the conclusions for each of the hypotheses tested. The statistical program used to analyze the collected data for all research questions was the Statistical Package for the Social Sciences (SPSS) Version 18.

Preliminary Analysis

Demographics

Participants were asked to self-report personal information on the demographics questionnaire as well as respond to three additional assessment instruments (The Traumatic Life Events Questionnaire [TLEQ], the PTSD Screening and Diagnostic Scale [PSDS] and the Trauma and Attachment Belief Scale [TABS]). Information provided by participants on the demographics questionnaire included gender, geographic location, educational background, employment information, and personal experience with counseling. The assessments provided information about the participants' experiences of trauma (or lack of), symptoms of Post Traumatic Stress Disorder (PTSD) and any disruptions in their cognitive schema (VT). The results of the demographics questionnaire are presented below and assessment results will be provided further along in this chapter.

A sample of n=114 counseling professionals volunteered to participate in this study. All participants were from a state in the Rocky Mountain region. Of the 114 participants 83.3% identified as female, 16.7% identified as male and no participants identified as transgender or any other gender identity. All participants met the educational requirements for participation, 86% of participants held Master's degrees and 14% held Doctoral degrees in the following areas: 43.4% in the field of psychology, 37.1% in the field of counseling, and 19.5% in the field of social work. One participant did not respond to the item addressing field of study.

All respondents were providing mental health services in their communities, 71% provided services in a mental health agency, 12% in private practice, 5% in university counseling centers and 1% in advocacy settings (including sexual assault and domestic violence service centers). The remaining 11% identified as working in other areas which they identified as hospitals and residential treatment centers.

Participants disclosed by self-report, if they had received counseling or mental health services related to a traumatic event and if so, what form of therapy they received. The majority of individuals, 94.8%, indicated they had experienced a traumatic event by responding "yes or no" to question 9: If you disclose having experienced a traumatic event, have you received counseling related to that event? 55.3% reported having received counseling, 39.5% reported they had not been to counseling and 5.2% replied that the question did not apply to them. Of those who had reported a history of counseling, 17.5% reported receiving Eye Movement Desensitization and Reprocessing (EMDR) therapy, 16.7% reported receiving Cognitive Behavioral Therapy (CBT), 9.6% reported a Humanistic approach to therapy, 2.6% reported receiving Family Counseling,

.9% reported receiving Existential Therapy, and 1.8% reported receiving Psychoanalytic Therapy. 7% of the sample population reported receiving other forms of therapy not identified in one of the previously mentioned groups. The remaining 43.9% indicated this question did not apply to them by writing in N/A (not applicable) or leaving the response blank (See Table 1).

Although no analysis was run regarding the above information on counseling experience, these data were collected to aid in providing context about the participants and sample population.

Table 1

Sample Demographics: Gender, level of education, field of study, work setting, recipient of counseling, and if so the type of counseling received

Variable	Frequency	Percent
Gender	N=114	
Male	19	16.7
Female	95	83.3
Level of Education	N=114	
Master's Degree	98	86
Doctorate Degree	16	14
Field of Study	N=113	
Counseling	42	37.1
Psychology	49	43.4
Social Work	22	19.5
Work Setting	N=114	
Mental Health Agency	81	71
Private Practice	14	12
University Counseling Center	6	5
Advocacy Center	2	1
Other	11	11
[a] Received Counseling	N=114	
Yes	63	55.3
No	45	39.5
Not Applicable	6	5.2
Type of Counseling Received	N=114	
EMDR	20	17.5
CBT	19	16.7
Humanistic	11	9.6
Family	3	2.6
Existential	1	.9
Psychoanalytic	2	1.8
Other	8	7.0
[b] Not Applicable	50	43.9

[a] Individuals implied they had experienced a traumatic event by responding yes or no to question 9: If you disclose having experienced a traumatic event, have you received counseling related to that event?

[b] Individuals wrote in either N/A or left this blank

In response to the demographics questionnaire, participants also self- reported information about their client caseload. Participants were asked specifically about the number of clients they were serving, the percentage of those clients who had disclosed a history of trauma, and if the counselor perceived this percentage to be low, average or high. Participant caseloads ranged from 0-200 clients with an *M*= 26.11 clients and a mode of 35 clients. 29% of participants reported having between 0-10 clients, 31% of participants reported having a caseload of 11-20 clients, 11%had a caseload of 21-30 clients, 12% reported between 31-40 clients, 6% had between 41-50 clients and 11% of participants reported having over 50 clients their caseload. One participant reported a caseload of zero based on current employment status; at the time of recruitment this participant had an active caseload, however when meeting with the researcher this individual was on winter break and did not have a client.

Participants also self-reported information regarding the percentage of clients on their caseload with histories of trauma. A majority of participants, 37%, reported that the percentage of clients with histories of trauma equated to over 80% of their caseload. The remaining participants reported the following: 19% reported between 60%-80% of their caseload to be clients with histories of trauma, 16% reported a caseload between 45%-60%, 14% reported individual clients with histories of trauma to make up between 10%-25% of their caseload, 10% reported a caseload between 25%-45%, and the remaining 4% indicated their caseload of clients with trauma was less than 10%.

When asked to evaluate whether they perceived this percentage of clients with histories of trauma to be low, average, or high the majority of participants, 57.9%, reported this percentage to be average, 35.1% of participants reported it to be high and

only 7% reported their caseload of clients with trauma to be low (See Table 2). Information regarding the counseling professional's perception of their caseload was collected for informative purposes which will be addressed in Chapter V; no analysis was run using the counselor's perception of their caseload of clients with trauma histories.

Table 2

Caseload: Current caseload and the percentage of clients with histories of trauma

Variable	Frequency	Percent
Number of Clients on Caseload	N=114	
<10	33	29
11-20	35	31
21-30	13	11
31-40	14	12
41-50	7	6
>50	12	11
Percentage of Clients with History of Trauma	N=114	
<10	4	4
10-25	16	14
25-45	12	10
45-60	18	16
60-80	22	19
80-100	42	37
Trauma Caseload	N=114	
Low	8	7
Average	66	58
High	40	35

Assessment Instruments

Traumatic Live Events Questionnaire Results

This instrument recorded the number of critical events (CE) identified by an individual as well as their experiences of intense fear, helplessness or horror related to the event. Based on self- reports, 96.5% of the sample reported experiencing at least one

critical event on the TLEQ and only 3.5% reported experiencing zero critical events. Among the sample 20.2% reported that they did not experience intense fear, helplessness, or horror and 79.8% reported experiencing these emotions on at least one occasion (see Table 3).

Table 3

TLEQ Results: The number of participants who experienced critical events and the number of participants who experienced intense fear, helplessness or horror during the event.

Variable	Frequency	Percent
Traumatic Life Events Questionnaire	N=114	
Critical Events		
CE < 1	4	3.5
CE > 1	110	96.5
Intense Fear Helplessness, Horror		
Fear, Helplessness, Horror < 1	23	20.2
Fear, Helplessness, Horror $\geq$ 1	91	79.8

Post Traumatic Stress Disorder Screening and Diagnostic Scale Results

This instrument assessed for symptoms of PTSD based on DSM-IV R criterion. Overall, 80% of the sample had mild to no symptoms of PTSD, 17% of the sample had mild to moderate symptoms, 2% had moderate to severe symptoms and 1% was experiencing severe symptoms of PTSD. The reported symptoms on the PSDS related to the most significant critical event (CE) identified by the participant on the TLEQ (see Table 4).

Table 4

PSDS Results: Participant scores related to PTSD symptomology and criterion

Variable	Frequency	Percent
PSDS	N=114	
None – Mild	91	80
Mild – Moderate	20	17
Moderate – Severe	2	2
Severe	1	1

Trauma and Attachment Belief Scale Results

This instrument was used to assess for VT. Participant scores were calculated using standard T-scores assigned to the TABS total score outlined in the assessment manual as follows: T $\leq$ 29 extremely low (very little disruption), T =30-9 very low, T=40-44 low average, T=45-55average, T=56-59 high average, T=60-69 very high, T$\geq$70 extremely high (substantial disruption; Pearlman, 2003).

The majority of participants, 40.4% scored in the average range, 3.5% scored extremely low, 28.1% scored very low, 17.5% scored low average, 3.5% were high average, 6.1% were very high and the remaining .9% were extremely high with substantial disruption (see Table 5).

Table 5

TABS Results: Participant scores for VT experience

Variable	Frequency	Percent
TABS	N=114	
Extremely low	4	3.5
Very low	32	28.1
Low average	20	17.5
Average	46	40.4
High average	4	3.5
Very high	7	6.1
Extremely High	1	.9

Research Questions and Analysis

There were four research questions posed for this study. The research questions, the hypotheses proposed by the researcher and the corresponding results are outlined below. It is important to note that there was no missing data recorded so no additional analyses were run to address any missing values.

Q 1: Is there a relationship between a mental health professional's history of trauma, symptoms of PTSD, and their experience of vicarious trauma?

This research question was split into two parts, the first part seeks to identify a relationship between an individual's history of trauma and VT and it was hypothesized that a relationship would exist between these two variables (H1). Part two of the research question seeks to identify a relationship between symptoms of PTSD and VT, and it was hypothesized that a relationship would also exist between these two variables (H2).

For part one of Q1 participants identified their personal histories of trauma on the TLEQ. The total number of traumatic experiences identified was recorded as a critical event (CE). Participants then completed the TABS to assess for VT and received a total

score, which converted to a standard T-score for reporting purposes. To address the potential relationship between an individual's history of trauma and their experience of vicarious trauma as identified in Q1, H1, a 2-tail Pearson Correlation was used. The independent variable (IV) measured was the participants' histories of trauma and the dependent variable (DV) measured was VT.

Results for part one of Q1 yielded a Pearson correlation co-efficient of r= .187, and a p-value of p=.046 at an α=.05 level of significance. Results indicate that no significant relationship exists between the number of traumatic experiences in a counselor's history and their experience of VT as scored by the TABS. Thus the results did not support the proposed hypothesis. An R^2 coefficient of determination was used to determine that only 3% of the TABS total VT score was impacted by the number of traumatic events in a counselor's history.

Under part two of Q1 participants completed the PSDS to identify symptoms of PTSD and the TABS to identify symptoms of VT. The PSDS provides a total score used to identify symptoms of PTSD and the TABS, as previously stated, uses a total score converted to a standard T-score. A Pearson Correlation co-efficient was used to determine if a relationship exists between the two variables where the IV measured was PTSD and the DV measured was VT.

A correlation did exist between PTSD symptoms and VT. Results yielded a statistically significant score of r=.376 and a p-value of p=.0001 at an α=.01 level of significance. There was a relationship between an individual's symptoms of PTSD and their experience of VT. An R^2 coefficient of determination was used to determine that 14% of the PSDS score is impacting the TABS total score.

Q 2: Is there a difference between the categorical type of trauma (ie: natural disaster, intimate partner violence, child abuse, interpersonal violence, accident, and death or illness) experienced by a counselor and their experience of VT?

It was hypothesized that a difference would exist between the type of trauma experienced by an individual and their experience of VT. It was anticipated that individual's with more severe traumas (interpersonal violence, child abuse, and intimate partner violence) would be more likely to experience VT. Incidents of trauma were recorded on the TLEQ and categorized by the researcher since this was not offered by the instrument. Categories were created in an effort to identify and provide various classifications of trauma and are reported in Table 6. VT was measured using the TABS total score.

Table 6

Categories of trauma: Frequency in which participants experienced events in each category.

Variable	Frequency	Percent
Natural Disaster	N=114	
Yes	37	32.5
No	77	67.5
Accident	N=114	
Yes	46	40.4
No	68	59.6
Death or Illness	N=114	
Yes	97	85.1
No	17	14.9
Interpersonal Violence	N=114	
Yes	74	64.9
No	40	35.1
Intimate Partner Violence	N=114	
Yes	39	34.2
No	75	65.8
Child Abuse	N=114	
Yes	56	49.1
No	58	50.9

A MANOVA (Multivariate Analysis of Variance) was conducted to determine if a difference exists between the various categories of trauma identified by the researcher and VT. The DV's for this analysis are the categories of trauma and the IV is VT. The results of the MANOVA are reported in Table 7 and discussed below.

Table 7

MANOVA: Differences between categories of trauma and VT.

Dependent Variable	Independent Variable	P
Categories of Trauma	TABS Total Score	
Natural Disaster		.787
Accident		.748
Death or Illness		.214
Interpersonal Violence		.087
Intimate Partner Violence		.247
Child Abuse		.149

MANOVA results do not support the proposed hypothesis as there were no significant findings. There does not appear to be a difference between the various categories of trauma and an individual's experience of VT. A value of R^2=.350 indicates that only 35% of the scores can be explained by VT. The category of interpersonal violence may be worth noting as there was a p-value of p=.087 indicating a nearly significant p value at an α=.05 level of significance. A Post Hoc analysis was conducted to account for variance among the categories.

Wilks' lambda was used to determine the amount of variance among the categories of trauma. The results of the Wilks' lambda demonstrated that the category of intimate partner violence influenced the data with a significant p-value of p=002. Additionally, the category of death or illness also had a nearly significant p-value of p=.055 (see Table 8).

Table 8

MANOVA: categorical variance

Effect	Multivariate Test	P
Categories of Trauma	Wilks' Lambda	
Natural Disaster		.391
Accident		.584
Death or Illness		.055
Interpersonal Violence		.232
Intimate Partner Violence		.002
Child Abuse		.353

Q 3: Are there gender differences in the frequency in which VT is experienced?

It was hypothesized that more women would experience VT than men. A t-test was used to determine if a difference exists between men and women and their experience of VT. The t-test was selected to compare the mean scores between genders. It may be relevant to note that both males and females scored, overall, within the average range on the TABS scale with males producing a mean score of 45.73 (average) and females producing a mean score of 44.82 (low average) indicating an average amount of cognitive disturbance.

The t-test yielded the following results: $t = 0.396$, SD of 9.20 at 112 df with an $\alpha=.69$ level of significance, no significant difference between men and women. Results for this research question did not support the proposed hypothesis that a difference would exist between male and female mental health professionals when experiencing VT.

Q 4: Is there a relationship between the number of clients with histories of trauma on a counseling professional's client caseload and the counseling professional's experience of VT?

It was hypothesized that a high caseload of clients (as defined by the participant) with histories of trauma would contribute to a mental health professional's experience of VT. A correlation co-efficient was used to determine if there was a relationship between the two variables. The IV was the response to question number seven on the demographics questionnaire (client caseload) and the DV was the total score on the TABS assessment tool (VT). Results yielded a weak correlation with a p-value =.229 and an r=.114 indicating no statistical significance supporting an association between the two variables. The results did not support the proposed hypothesis; no relationship exists between high caseloads of clients with trauma histories and a mental health professional's experience of VT.

Further details and discussion of the results presented in this chapter and their applicability to the field of counseling and counselor education will be provided in Chapter V.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

This chapter presents a discussion of the results of this research study. This discussion will address findings as they pertain to each research question and the relevance of these findings as they relate to the available literature. In addition to the research outcomes this chapter will also address the limitations of the study, the implications of the findings and directions for future exploration.

Summary of Findings

History of Trauma, Vicarious Trauma, and Post Traumatic Stress Disorder

The research conducted explored possible contributing factors to the phenomenon of vicarious trauma (VT). Two potential factors investigated were a counselor's history of trauma and any existing symptoms of Post Traumatic Stress Disorder (PTSD). Based on the outcomes of prior research conducted, such as that of Pearlman and Mac Ian (1995) and Trippany, Wilxoxon, and Satcher (2003), it was expected that counselors who had experienced traumatic events during their lifetime would be greatly impacted by VT. Because of the anticipated relationship between history of trauma and VT the potential relationship between symptoms of PTSD and VT was also explored.

Results of this research did not support the existence of a relationship between history of trauma and VT in this sample. Although the expectation of a relationship was

based on the outcomes of some of the initial studies on VT, results of this research appear consistent with other studies such as those by Devilly, Wright, and Varker (2009) and Schauben and Frazier (1995), where no relationship was found.

The discrepancy in the literature continues to be of concern as it sends mixed messages to counseling professionals regarding their own experiences of trauma and the likelihood that they will experience VT. Continuing to explore potential correlations using a variety of methods is necessary. The inconsistencies in the literature may exist for a variety of reasons, including different sample populations, limitations in methodology, and limitations in instrumentation.

To address any discrepancies regarding a relationship between an individual's history of trauma and VT future research may wish to consider using a variety of methodology including qualitative interviews, additional quantitative measures or mixed methods. Further exploration of a relationship between history of trauma and VT could include quantitative analysis, such as that which is presented here, where additional information from the assessment instruments is used; for example, identifying a correlation between trauma history and each of the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) subscales versus the TABS total score. Another example would include using only those critical events (CE's) identified on the Traumatic Life Events Questionnaire (TLEQ; Kubany, 2004) where an individual indicated they experienced intense fear, helplessness and horror when the event occurred rather than using the total number of CE's experienced, then explore a correlation with VT.

In addition to quantitative options, future researchers wishing to continue exploring a relationship between trauma and VT may also consider qualitative interviews

with questions specifically targeting the unique aspects of VT, such as the permanent changes in cognitive schema, which seems to set VT apart from secondary traumatic stress (STS) or burnout. Perhaps, in order to bridge the gap between qualitative and quantitative literature, researchers could approach this relationship by way of mixed methods designs. Using this approach information can be gathered via assessment and further explored using in-depth interviews or focus groups.

The exploration of PTSD as a potential contributing factor to VT yielded slightly different results. Previous research has identified that counselors with high caseloads of trauma survivors report more PTSD like symptoms, such as distress, anxiety, and intrusive thoughts or images (Brady, et al., 1999, Chrestman, 1999, Kassam-Adams, 1999). This study explored symptoms of PTSD, as they relate to an individual's history of trauma, and the relationship with VT. It was anticipated that current symptoms of PTSD would impact a mental health professional's exposure to VT when working with clients. As anticipated, a significant relationship was found between PTSD and VT for participants in this sample.

The relationship identified between PTSD and VT may be due to similarities in symptomology between the two. Symptoms of PTSD often overlap with symptoms of secondary traumatic stress (STS) and VT. It may also be related to the severity of the trauma identified by the participant. For example, the instruments used for the purposes of this study focused on PTSD symptoms as they related to traumatic experiences identified on the TLEQ. Individuals with no histories of trauma were likely going to identify few to no symptoms of PTSD, whereas individuals with more severe histories of trauma were likely to report more symptoms of PTSD and, perhaps, VT.

Further exploration of the relationship between PTSD and VT could include studies involving comparison groups, such as individuals with a history of trauma and those with no history of trauma. In the proposed sample both groups would complete a PTSD symptom inventory, unrelated to a specific traumatic event, as well as a VT assessment. The results of the current study signify a need for additional review and research in this area to differentiate between vicarious trauma and PTSD.

Type of Trauma and the Experience of Vicarious Trauma

A unique contribution from this study was the exploration of categories of trauma as a variable in experiencing VT. The categories of trauma were created by the researcher and the traumatic experiences, which were assigned to a specific category, were identified using the Traumatic Life Events Questionnaire (TLEQ; Kubany, 2004). The categories identified were; natural disaster, accident, death or illness, interpersonal violence, intimate partner violence and child abuse. Some research has investigated VT in populations of providers serving survivors of sexual violence and intimate partner violence, such as those by Baird and Jenkins (2003), Schauben and Frazier (1995), and Trippany et al., (2003). However, it is unknown if other studies to date have explored types of trauma experienced by counseling professional versus specific client populations.

Prior research suggests that traumas which can be perceived as malicious in nature increase the likelihood of symptoms of PTSD (Vogt et al., 2007). Based on this knowledge, it was anticipated that counselors who experienced events that may be considered pervasively traumatic such as child abuse, interpersonal violence, and intimate

partner violence, would experience VT at higher rates than their peers. Research results from this sample did not support this claim. Among the categories of trauma presented above, as reported on the TLEQ, results of this study indicated there were no significant differences among any of the categories.

Further analysis for variance among the categories, using Wilks' Lambda, did identify intimate partner violence to be an influential variable which may warrant further exploration. Intimate partner violence may have been more influential than the other categories of trauma because this form of violence is often deliberate and involves some form of betrayal which can lead to more psychological distress (Allen, 1995; Courtois & Gold, 2009). If conducting a study similar to the one presented here, future MANOVAS could also include additional independent variables, such as PTSD or STS, in conjunction with VT.

The lack of significant results, indicating no difference among the categories of trauma, may be due to the over-generalized nature of the categories. For example, the category of child abuse incorporated the experiences of physical abuse, sexual abuse, and sexual assault for those under the age of 18. Perhaps creating more specific categories would allow researchers to identify areas of trauma that might influence VT. To explain further, the category of child abuse could be divided the type of abuse, physical or sexual, then by perpetrator or by age, or the number of occurrences. The new category of child abuse would include sexual abuse, then sexual abuse by a parent, sexual abuse by a relative, sexual abuse under the age of ten and so on. There may be a difference among categories of trauma and their relationship to VT if these categories were broken down into very specific sub categories.

Additionally, if choosing to use the TLEQ (Kubany, 2004) to identify trauma history, one may wish to consider analyzing a correlation between those CE's where feelings of intense fear, helplessness, or horror have been identified versus all CE's identified. It may also be beneficial to explore a connection between the events associated with fear, helplessness and horror, symptoms of PTSD and symptoms and VT. If individuals identify these intense feelings, clearly they perceive those events to be more disturbing that those CE's that did not evoke such strong reactions.

Gender and the Experience of Vicarious Trauma

Previous literature provided several possible contributing factors to VT, gender has been mentioned and some studies have identified sample populations of women only, however no studies exploring a difference between genders were identified.

Although men and women are both at risk for being exposed to, or experiencing, trauma women may experience higher numbers of trauma than their male counterparts because they are often targeted as crime victims, particularly in the areas of sexual abuse and intimate partner violence (Allen, 1995; Briere & Scott, 2006; Friedman et al., 2007; Kimerling, et al., 2007; Sher, 2004), it was anticipated that women would be more likely than men to experience VT as well as experience it in higher numbers. The results of this study did not support the proposed hypothesis that female counseling professionals would experience more VT than males. Results actually identified that male counselors experience VT to the same degree as their female peers. In fact, based on the results of this particular study the rate at which this sample of participants experienced VT was average (as identified by Pearlman, 2003). There were no statistically significant results

from this sample to support the notion that one gender experiences VT more than another.

There may be a variety of explanations as to why no difference between genders was discovered. In a study where the overwhelming majority of participants were female (83.3%) it is unlikely that VT exposure among male counselors was accurately represented. Additionally, women are more likely to reveal their own history of victimization (Allen, 1995; Briere & Scott, 2006; Friedman et al., 2007; Kimerling et al., 2007, Sher, 2004). Due to stigmas around gender and the societal expectation that males portray themselves as masculine, it is possible that the limited number of male participants responded in a manner that may be considered politically or socially appropriate, on the TABS (Pearlman, 2003). Finally, given that both males and females scored within the average scoring range on the TABS, indicating an average level of cognitive disruption, perhaps the lack of differentiation in scores between men and women is due to the possibility that VT is not as pervasive among counseling professionals as the literature has implied.

Further exploration of gender as a contributing factor to VT would require more male participants. It may also be of interest to explore more diverse populations of participants such as counselors who identify as gay, lesbian, transgender or other gender identity.

Clients' Histories of Trauma and Vicarious Trauma

Prior research indicates that counselors with high caseloads of clients with traumatic histories experience VT at higher rates than their peers (Chrestman, 1999). Other research studies have found no relationship between caseload and VT (Baird &

Jenkins, 2003). In an effort to bridge the gap and further contribute to the literature this study addressed caseload as a variable for experiencing VT. It was hypothesized that counselors with self-reported caseloads high in clients with traumatic histories would experience high rates of VT. Again, results from this study did not support the proposed hypothesis.

Counselor attributes, such as those explored in this study contribute to the experience of VT. Additionally, client attributes can also influence a counselor's experience of VT such as the client's feelings of hopelessness or their level of suicidality (Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b). Furthermore, the nature of the traumas experienced by clients could also influence VT, for example Schauben and Frazier (1995) found that counselors with high rates of sexually victimized clients on their caseloads experienced more disruption in their own cognitive schemas, a characteristic of VT. This study only reviewed the counselor's caseload in terms of the percentage of trauma clients rather than exploring the characteristics of the clients themselves. The lack of in-depth information regarding client attributes may explain why no relationship between caseload and VT was identified in the present study.

Further expansion of the present study could include identifying additional information about the nature of the clients served by counselors. Rather than just ascertaining the number of clients with histories of trauma, future research could distinguish between the percentage of clients with histories of sexual trauma or the number of clients with persistent and pervasive thoughts of suicide or the number of clients currently in crisis due to a recent traumatic event. Each of these variables may

further contribute to understanding the influence a counselor's caseload may have on their experience of VT.

Limitations

External Validity

Although the recommended minimum number of participants for this study was N=114, as identified using G-power software (Faul, et al., 2009; Faul, et al., 2007), this could be considered a small sample size relevant to the needs of the study, thus limiting the statistical power of the analyses performed. In addition to the small sample size, this particular group of participants may not be representative of the total population of counselors. This sample population was specific to one particular geographic location in the Rocky Mountain region and may not be generalizable to the profession as a whole or to other professionals in various geographic locations. Based on geographic location there may be variations among participants in terms of access to resources, training opportunities, level of education and access to supervision.

Additionally, there may be differences in this population based on the type of work setting where counselors are providing services. For example, individuals in larger agencies may have more access to supervision and training than individuals in private practice or advocacy settings. Also, the sample was made up of volunteer participants, several of whom contacted the researcher directly upon hearing about the research from another participant versus responding to a flyer or other method of recruitment indicating a strong interest in the topic of study.

In addition to the sample size, location and recruitment strategies, participants may have felt obligated to respond to surveys in a neutral way demonstrating their overall

mental wellness. Mental health professionals are expected to be familiar with the symptoms of PTSD and may also be familiar with the symptoms of VT as it continues to be presented in the literature. Their familiarity with symptomology and the potential expectation that counselors present as mentally stable, may have influenced responses on the questionnaires. Participants were also observed while completing the assessment instruments and although their results were anonymous and the instruments were not reviewed or scored in the presence of the participant, this may have influenced responses. Further discussion of the instrument limitations will be provided in the next section.

Other characteristics of the sample population that could have influenced results may include the fact that more than 50% of the participants in this study reported having already received some form of counseling or mental health services to assist them in their recovery from their traumatic experiences, potentially minimizing their likelihood of experiencing VT. From that group 17.5% received EMDR and 16.7% received CBT, both evidenced based treatments. When identifying contributing factors to VT, Pearlman and Saakvitne (1995a; 1995b) noted that counselors who harbor unprocessed trauma material are at risk for experiencing VT. Because of this risk, mental health counseling and support is one of the recommendations outlined in the literature to combat symptoms of VT (Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b). An additional factor to consider may also be overall improved mental health treatment options and available pharmacology for individuals. In addition to having received counseling support some participants may also have been prescribed medication to reduce symptoms of depression or anxiety. Any medication may also play a role in reduced symptoms of

VT among this sample; however counseling treatment and pharmacology were not explored in the present study.

External factors which may contribute to counselors seeking mental health support for traumatic experiences could include quality employee assistants programs and access to health care plans which include mental health services as payable or reimbursable expenses. Improved quality and access to mental health services among a population of practitioners, who most likely value seeking mental health care, could explain the lack of significant findings for several of the research questions. Specifically the relationship between a history of trauma and VT, the lack of significant findings among the various categories of trauma and the lack of difference between genders as well as caseload.

Instruments and Measurement

Additional explanations for the lack of relationship may be related to the instruments selected. The assessment instruments selected had strong validity and reliability, however all instruments relied on self-reporting by participants. The TLEQ (Kubany, 2004) asks specific questions related to events experienced in one's life that may be perceived as traumatic. However, perhaps individuals indicating a critical event (CE) in their past did not necessarily perceive that CE to be traumatic in nature. Furthermore, the TLEQ does not categorize the responses into categories, that was done manually by the researcher which may have led to human error or inconsistencies in recording information. Although the researcher followed a formula for associating specific questions on the TLEQ to an assigned category there was room for error. As

suggested earlier, identifying more specific categories of trauma may reduce the likelihood of error because the categories would be very specific to the traumatic event.

Additionally, the instrument used to measure VT was initially created to measure cognitive disruptions in relationship to traumatic experiences, and adopted to measure VT (Pearlman, 2003). Perhaps there is a need to create an instrument solely to measure VT, one that assesses for VT, PTSD / STS and burnout. An instrument or inventory that identifies symptoms of each trauma related phenomenon including flashbacks, nightmares, exhaustion, etc., as well as the changes in cognitive schema and cognitive disruptions specifically associated with VT. An instrument of this sort would further aid in differentiating between the symptoms related to each experience and potentially eliminate further confusion and overlap.

Implications

The present study focused primarily on contributing factors to VT, including prior history of trauma, symptoms of PTSD, types of trauma, gender, and caseload. This research is based in the assumption that VT is prevalent among counselors. Previous and present literature continues to present VT as factual, implying that counseling professionals working with survivors of trauma are at risk of exposure to VT. Based on the current findings in this study perhaps counselors will begin to consider VT to be a phenomenon or theory necessitating further exploration.

Most research on the topic of VT appears to be presented as factual via on-going reviews of past literature on the topic while including recommendations for self-care and education (Bride, 2004; Jordan, 2010; Kadambi & Ennis, 2004; Neumann & Gamble, 1995; Newell & MacNeil, 2010; Sabin-Farrell & Turpin, 2003; Sommer, 2008; Trippany,

White Kress, & Wilcoxon, 2004). If the phenomenon of VT continues to be presented in the literature as an inevitable experience that comes from working with trauma survivors, without continued research and exploration of the phenomenon, then the field is making recommendations for self-care based on reviews of the literature rather than empirical research. Further research is needed to explore the conditions under which VT develops and solidify what factors actually contribute to the phenomenon so that the self care, professional development and treatment options are consistent and appropriate for addressing symptoms of VT.

Implications for Clinicians and Supervisors

Sommer (2008) informs us that "educators have an ethical obligation to inform counselors regarding the dangers inherent in working with clients who are traumatized" (p 65). The implication here is clear, mental health professionals are directly impacted by trauma work and need specific training and supervision on providing these services. However, based on the results from this sample perhaps VT is not as prevalent for counselors as is being portrayed.

The implications for professional practitioners and supervisors are the need for more education on the topic of VT and a more thorough review of the differentiations between VT, STS / PTSD and burnout. When providing supervision, supervisors who are unaware of, or who have been misinformed, of the overlap in symptomology between the three conditions may unintentionally address only the common symptoms and not the overall cognitive disruptions that clearly differentiate VT from STS and burnout. It is imperative that supervisors be educated and informed about VT.

Counseling professionals should be well educated on the symptoms of burnout. For those individuals doing extensive work with survivors of trauma, it is imperative that they further educate themselves about other potential side effects to working with these individuals such as experiencing vicarious trauma and / or secondary traumatic stress, as well as being able to differentiate between the two. Although symptoms such as flashbacks, intrusive thoughts, and avoiding activities that once were pleasurable are symptoms of both STS and VT, what sets VT apart is the permanent changes in cognitive schema that occur as a result of trauma work.

Implications for Educational Programs

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) emphasizes in all categories, that programs in all content areas, should include education on the "effects of crises, disasters, and other trauma-causing events on persons of" all ages; with addictions; on marriages, couples, families, and households (CACREP, 2009). As these accreditation requirements have been laid out, there is the expectation that programs are preparing newly trained counselors to understand theory and best practices around trauma work. Given the nature of this important work it is appropriate to discuss the potential impact trauma work may have on professionals. As stated above, programs should consider thoroughly educating students on the differences between burnout, compassion fatigue or STS, and VT.

Education on these issues could be incorporated into courses on trauma and crisis as well as practicum courses both at the Masters and Doctoral levels. Additionally, programs could encourage faculty and students to attend professional development opportunities that also address the impact of trauma work.

Suggestions for Future Research

"Evidence to support the concepts of vicarious trauma and secondary trauma is meager and inconsistent" (Sabin-Farrell & Turpin, 2003, p. 467). The need to continue researching the topic of VT is prevalent. Results of this study continue to contribute to the inconsistencies in the literature particularly as it relates to the prevalence of VT among mental health professionals. It may benefit counseling practitioners as well as supervisors and educational programs, to truly identify the prevalence of VT. To further understand this consideration, future researchers may wish to consider a longitudinal study that identifies clinicians graduating from clinical programs with little to no experience working with clients and follow them over the course of their careers and reassessing for VT periodically. Using the TABS (Pearlman, 2003) as a pre-test for individuals entering the field and the reassessing over time with the same instrument to determine the onset of VT and identify a percentage of clinicians who are experiencing symptoms.

As suggested earlier in this chapter, future research would continue to benefit from further exploring any relationship that may or may not exist between trauma history and VT. Rather than identifying the number of traumatic experiences in an individual's history, as did this study, researchers may consider identifying those critical events that participants rated as having caused intense fear, helplessness, or horror, in correlation with the TABS (Pearlman, 2003) assessment for VT.

It may also be advantageous to identify a larger sample of counselors who do not identify has having had a traumatic experience, whereas 96.5% of this sample reported experiencing a critical event. What was not further identified in this study was exploring

which of those critical events disclosed were egregious or traumatic in nature. As suggested earlier, identifying more specific categories of trauma may offer more clarification on the types of traumas in an individual's history that may further expose them to VT.

In conjunction with further exploring any connection, or lack thereof, between history of trauma and VT, researchers may wish to consider any possible relationship between counselors who had received counseling and those who have not, as a potential factor in preventing or minimizing the experience of VT, as it may have been the case in this study. Exploring this area using pre and post counseling groups may lead to further understanding of the benefits of counseling in preventing VT.

Given the continued conflicts in the literature creating a mixed methods design and exploring the variables explored in this study, may lend itself to further understand where the discrepancies exist in identifying contributing factors to VT. Mixed methods studies could include any number of assessment instruments measuring STS, burnout, PTSD, and VT and could also include extensive interviews exploring a counselor's own history of trauma, their experience in the field, the characteristics of their client population, their own experiences of counseling, and any changes in their own beliefs about safety, intimacy, control (or other needs areas associated with VT) they have noticed over the course of their work. The possibilities for mixed methods design seem endless.

It is also important to note that some of the previous studies focused primarily on counselors working with survivors of sexual violence, future research may benefit from isolating practitioners working with specific populations, such as military veterans, child

abuse survivors, as well as survivors of sexual trauma to identify if VT is more prevalent among practitioners working with certain populations versus those with varying caseloads.

Finally, continued research to elaborate on and differentiate between VT and other terms or conditions that simulate similar symptomology, such as PTSD, STS, and burnout, should be explored.

Summary

Inevitably, counselors will work with clients who have survived trauma. Some counselors will dedicate their professional careers solely to working with individuals who have suffered from traumatic events and are on the road to recovery. In their work with these clients counselors are exposed to the horrors of the world. They may encounter clients who have been egregiously abused by loved ones physically, emotionally, or sexually. They may work with children who have suffered severe abuse by parents or other care takers, or individuals returning from war who have seen indescribable tragedy. Through this work counselors listen to their clients' stories in great detail as they process, work through, and help clients reframe their experiences. Counselors do this with empathy, they listen and nurture and absorb the details of their clients' histories. Naturally, those engaged in this work would be affected by it.

In order to provide appropriate education, training, professional development, support and treatment to counselors working with traumatized populations the profession must thoroughly explore the various ways clinicians can be impacted by the nature of their work. That exploration includes identifying the contributing variables to the phenomenon known as vicarious trauma. Over the last decade it appears that the original

studies on vicarious trauma have morphed into summary articles offering warnings about the dangers of working with survivors of trauma and offering self-care strategies for professionals to limit symptoms they may be experiencing. What is missing is continued research and exploration on the variables contributing to vicarious trauma. That is what was offered by the present study.

Based on the results of this sample population it is evident that additional, more in-depth research is needed so that the counseling profession can continue to educate students, support practitioners, and guide supervisors in their work with traumatized individuals. Counselors may wish to further explore the liberal application of the term vicarious trauma and consider the eagerness with which VT is discussed as an experience all clinicians will be exposed to in their work. Perhaps future research will support the idea that vicarious trauma is a rare side effect of pervasive, in-depth trauma work and continue to provide exploration and recommendations for the field of counseling.

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APPENDIX A

DEMOGRAPHICS QUESTIONNAIRE

Demographics Questionnaire

1. What is your current state of residence? _____
2. What is your gender? ☐ male ☐ female ☐ transgender ☐ other
3. What is your highest level of education completed? _____
4. In what field of study is your degree? _____
5. Do you currently work in a mental health agency? ☐ yes ☐ no
   a. as a private practitioner? ☐ yes ☐ no
   b. in a University Counseling Center? ☐ yes ☐ no
   c. in an advocacy setting? ☐ yes ☐ no
   d. Other: _____
6. What is the total number of clients on your current caseload? _____
7. What percentage of your current client caseload consists of clients with a history of traumatic experiences? (circle one)

   ☐ < 10% ☐ 10%-25% ☐ 25%- 45%

   ☐ 45%- 60% ☐ 60%- 80% ☐ > 80%
8. Do you consider this percentage: ☐ low ☐ average ☐ high?
9. If you disclose having experienced a traumatic event, have you received counseling related to that event? ☐ yes ☐ no
10. If so, what type of counseling? (examples: EMDR, CBT, Humanistic, etc.) _____

    _____

    _____

APPENDIX B

AGENCY PERMISSION FORM

UNIVERSITY of NORTHERN COLORADO

Permission to Enter Agency for Participation in Research
Applied Psychology & Counselor Education
Project Title:

A Study Exploring the Relationship Between Personal Trauma, Gender, and the Experience of Vicarious Trauma Among Counseling Professionals.

Lead Researcher: Kristin Kushmider, MA. (970) 584-9833, kristin.kushmider@unco.edu
Research Advisor: Heather Helm, PhD. (970) 351-1630, heather.helm@unco.edu

I _____ have been provided information regarding the
(name)

study titled A Study Exploring the Relationship Between Personal Trauma, Gender, and the Experience of Vicarious Trauma Among Counseling Professionals. As

_____ of _____ I give Kristin Kushmider
(title) (agency name)

permission to contact potential participants within the agency.

Signature of Administrator:

_____

Signature of Witness:

_____

APPENDIX C

INFORMED CONSENT

UNIVERSITY of NORTHERN COLORADO

Informed Consent for Participation in Research
Applied Psychology & Counselor Education
Project Title:

A Study Exploring the Relationship Between Personal Trauma, Gender, and the Experience of Vicarious Trauma Among Counseling Professionals.

Lead Researcher: Kristin Kushmider, MA. (970) 584-9833, kristin.kushmider@unco.edu
Research Advisor: Heather Helm, PhD. (970) 351-1630, heather.helm@unco.edu

The goal of this research is to identify the prevalence of vicarious trauma among counseling professionals and to further clarify the factors which contribute to this phenomenon. Your voluntary participation is greatly appreciated.

As a participant, you are being asked to donate 20-40 minutes of your time which involves completing a demographics questionnaire, as well as three screening assessments. The first assessment is the Traumatic Life Events Questionnaire (TLEQ), which asks general questions about any exposure you may have had to a stressful or traumatic event. Items in the TLEQ are related to potentially traumatic events such as automobile accidents, the unexpected death of a friend or family member, abuse, and other similar circumstances. You will then be asked to complete the Post Traumatic Stress Disorder Screening and Diagnostic Scale (PSDS). The PSDS asks about distress and functioning in areas of social life, personal relationships, work, and religion as they relate to a traumatic experience. Finally, you will be asked to complete the Trauma and Attachment Belief Scale (TABS) which assess the impact counseling survivors of trauma has on a mental health professional's cognitive beliefs. Responses to these survey assessments may cause you to experience mild levels of anxiety or emotional discomfort, but is not expected to be greater than what you may experience working with clients. Given the personal nature of some of the questions, you will receive a trauma debriefing form which outlines common responses to stressful events, as well as a resource list identifying potential resources in your community.

Your participation in this study will remain strictly confidential. Beyond the primary researcher and research advisor, no one will be allowed to see or discuss any of your responses. To ensure your confidentiality, no identifying information is required on the survey assessments and the survey assessment responses and signed consent form will be kept separately. Individual responses from this study will be combined with all other

responses and reported collectively for publication. All data will be kept in locked files in the researcher advisor's office and all survey responses will be destroyed after five years.

Your participation in this study will most likely not result in any direct benefits to you as an individual but it may help you to further understand any changes you may have experienced as a result of working with survivors of trauma.

Your participation in this study is voluntary. You may decide not to participate in this study, and, if you begin to participate you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado, Greeley, CO 80639; 970-351-2161.

Please feel free to contact me if you have any questions or concerns about this research and please retain one copy of this letter for your records. Thank you for assisting me with this important research.

Sincerely,

Kristin Kushmider, MA

_____ _____

Participant Signature Date

_____ _____

Researcher Signature Date

Cut here

Amazon.com Gift Card Raffle

Name: _____

Phone: _____ Email:

_____

Preferred method of contact: ___ Phone ___ Email

APPENDIX D

PARTICIPANT RECRUITMENT FLYER

UNC Student Dissertation Research

Volunteer Participants Needed

Title

A Study Exploring the Relationship Between Personal Trauma, Gender, and the Experience of Vicarious Trauma Among Counseling Professionals.

The purpose of this study is to determine which personal characteristics held by a counselor or mental health practitioner may lead to vicarious trauma.

Participant Incentives

Eligible to win a $50 Amazon.com gift card

Free registration for a 1 hour training on vicarious trauma

If you are interested in participating in this study please contact Kristin Kushmider

Participant Qualifications

- Master's Degree or higher in counseling , psychology or related field
- Working in a clinical, mental health, employee assistance program, or victim advocacy setting
- Can donate approximately 30 minutes to complete assessments
- Assessments to complete include:
- Traumatic Life Events Questionnaire (TLEQ)
- PTSD Screening and Diagnostic Tool (PSDS)
- Trauma and Attachment Belief Scale (TABS)

Email: Kristin.kushmider@unco.edu
Phone (970) 351-2798
Cell: (970-584-9833

APPENDIX E

TRAUMATIC LIFE EVENTS QUESTIONNAIRE HANDOUT

Handout for participants who have completed the TLEQ in a research setting

(Kubany, 2004)

The *Traumatic Life Events Questionnaire* (TELQ) that you just completed asked about many types of very stressful events that are considered traumatic. These kinds of events can harm a person's emotional well-being or quality of life. Traumatic events involve exposure to actual or threatened death or serious injury or violation of one's physical boundaries. These events can be traumatic if they happen to us, if we witness them, or if they happen to someone we care about. When people experience these events, they may feel terrified, horrified, or completely helpless. We believe that knowing about the kinds of problems that traumatic events can cause may help explain problems you are having that may have you puzzled and may help you to realize you have options or choices that you didn't know you have.

After people experience a traumatic event, they may develop symptoms of post-trauma stress, which in some cases may last for a long time. The questionnaire that you completed asked you about 20 problems that people experience after traumatic events, including distress when reminded of the event, efforts to avoid reminders of the event, and guilty about the event. We would like you to know a little bit more about these problems and the effects they can sometimes have.

Symptoms of posttraumatic stress are considered to be normal reactions to extreme stress. When really bad things happen to people, these are the symptoms that often develop. These symptoms are *normal* human reactions to extreme stress. They have nothing to do with your personality or strength of character and do *not* mean that you are crazy or are going to go crazy. If someone else had the same experiences, there is a very good chance that he or she would be having the same kinds of problems.

Three of the feelings addressed in the TLEQ questionnaire are particularly important to know about. Relieving them can help a person recover from the effects of posttraumatic stress. These three feelings are guilt, anger, and grief related to the event. Guilt, in particular, is an extremely common feeling among trauma survivors. It is a symptom of posttraumatic stress just as fever is a symptom of an infection. Unfortunately, trauma survivors tend to experience guilt whether they deserve to or not. However, it is very important to know that trauma survivors often exaggerate the importance of their role in the trauma. They experience guilt that has no logical or rational basis. Getting rid of this kind of guilt can help trauma survivors feel much better.

Traumatic events can also be responsible for other problems. They can lead to depression, panic attacks, alcohol or drug abuse, eating disorders, and other emotional difficulties. The experience of a traumatic event can even harm a person's physical health and lead to medical problems, including pain.

If you have trauma-related problems that are severe, and if they have still not gone away 3 to 6 months after the trauma has ended, they may never go away completely without therapy or counseling. This does not mean that if you have these symptoms you must do something about them now-or ever! However, knowing the effects that trauma can have on a person's emotional and physical health may suggest choices that you did not know you have. Many trauma survivors choose to suppress, or "stuff," their memories because this way of coping has worked in the past. Many trauma survivors do

get along okay trying to “stuff” the trauma rather than talking about it. It is perfectly okay to do this. Trying not to think about what happened is a very common way for many survivors to cope with the trauma. On the other hand, some trauma survivors who do not want to deal with the trauma immediately may choose to address trauma-related problems later when they feel “stronger” or “more ready” to deal with the issues.

Even though it is completely natural not to want to talk about painful life experiences, it may actually be helpful to “get it out” or talk about what happened. In fact, complete recovery from the effects of trauma may often require that the person talk or think about the trauma to take the charge out of the painful memories, gain new insights about the trauma , and put what happened into proper perspective. Symptoms of posttraumatic stress seldom go away completely if the person continues to avoid thinking and talking about the trauma and avoids reminders of it.

To conclude, knowing that traumatic events can affect emotional and physical health may empower you by giving you choices you did not realize you have. If you know about the effects that trauma can have, you may finally make sense out of some problems that in the past have seemed weird or hard to explain. Please feel free to talk to the staff about you experience completing these questionnaires and any issues that may have come up for you. Also feel free to ask for a referral to a mental health professional who specializes in trauma of Posttraumatic Stress Disorder (PTSD).

APPENDIX F

PARTICIPANT RESOURCE LIST

Participant Resource List

Resource and Referral List for National Referrals

Counselor Find:
http://www.nbcc.org/directory/FindCounselors.aspx

The Family & Marriage Counseling Directory:
http://family-marriage-counseling.com/

Network Therapy: Find a therapist
www.Networktherapy.com

Appendix G

Participant Resource List

Resource and Referral List for Fort Collins

- Front Range Counseling: 3938 John F Kennedy Pkwy, Unit 11d, Fort Collins, CO 80525, (970) 207-1368
- Affiliated Counselors & Family: 383 W Drake Rd, Fort Collins, CO 80526 , (970) 223-9953
- Emery Counseling: 803 E Mulberry St, Fort Collins, CO 80524, (970) 490-1309

APPENDIX G

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY of NORTHERN COLORADO
Institutional Review Board (IRB)

May 10, 2010

TO: Mark Riddle
Sociology

FROM: Gary Heise, Co-Chair GDH
UNC Institutional Review Board

RE: Expedited Review of Proposal, *A Study Exploring the Relationship between Personal Trauma, Gender, and the Experience of Vicarious Trauma,* submitted by Kristin Kushmider (Research advisor: Heather Helm)

First Consultant: The above proposal is being submitted to you for an expedited review. Please review the proposal in light of the Committee's charge and direct requests for changes directly to the researcher or researcher's advisor. If you have any unresolved concerns, please contact Gary Heise, School of Sport and Exercise Science, Campus Box 39, (x1738). When you are ready to recommend approval, sign this form and return to me.

I recommend approval as is. Mel D Riddle 5/28/10
Signature of First Consultant Date

The above referenced prospectus has been reviewed for compliance with HHS guidelines for ethical principles in human subjects research. The decision of the Institutional Review Board is that the project is approved as proposed for a period of one year: 9 June 2010 to 9 June 2011

Gary D. Heise 9 June 2010
Gary Heise, Co-Chair Date

Comments: emailed 1 June 2010